

DEPT.- 65

JOB- 21

REEL- 43



**CITY OF BALTIMORE**

**HEALTH DEPT.**

**BUREAU OF**

**VITAL STATISTICS**

**DEATHS**

**BEGINNING 1910**



CITY HALL  
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE  
RECORDS MANAGEMENT DIVISION

## DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT  
THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE  
DEPARTMENT OF Health BUREAU OF Vital  
Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS  
AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COM-  
PLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PRO-  
VIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION  
NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN  
ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR  
ON JUNE 4, 1954.

## REQUEST FOR RETENTION PERIOD

To: Records Management Officer,  
Room 408, City Hall, Baltimore, 2, Md.

Authorization No.

345

Department:

Health

Bureau:

Vital Statistics

## Record Identification

1. TITLE: <b>Certificate of Death</b>		2. Form No. if available		3. Type—(cards, paper, etc.) <b>Bound Book</b>	
4. Dates		5. Volume accumulated yearly		7. Number of copies made <b>One (1)</b>	
6. Size of Record <b>Misc.</b>					

8. Authorization Requested (check only one (1) of the squares below)

A. Establish retention period for records which are accumulating daily. <input type="checkbox"/>	B. Dispose of present accumulation, no additional accumulation anticipated. <input type="checkbox"/>	C. Microfilm and destroy originals. <input type="checkbox"/>	D. Microfilm and retain originals for length of time indicated below. <input checked="" type="checkbox"/>
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9. Recommended Retention Period

a. In Dept. <b>12 yrs.</b>	b. In Storage Center <b>Micro. Perm.</b>	c. Total <b>12 yrs. and Micro. Perm.</b>	10. Equipment and space freed.	11. In your opinion does this record have any historical significance? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes. Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval

*Robert E. Fairley, M.D.*  
Title: Commissioner of Health

*3/28/63*  
Date

## Recommendation of Records Management Officer

13. Recommended Retention Period			14. Disposal Method		
a. In Dept. <b>12 yrs.</b>	b. In Storage Center <b>Microfilm Permanent</b>	c. Total <b>12 yrs. and Microfilm Permanent</b>	A. To be sold as scrap or waste paper <input type="checkbox"/>	B. To be burned or shredded <input checked="" type="checkbox"/>	C. Historical, (to be transferred to Dept. of Legislative Reference.) <input type="checkbox"/>

REMARKS:

*2 negative rolls*

Records Management Officer

*C. P. Force*

*3/28/63*  
Date

## APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER  
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE



**FILED ON FILM**

**IN**

**NUMERICAL ORDER**

# **NOTICE**

The succeeding documents  
were received in the same  
condition and microfilmed  
as shown.

Every effort was made to  
assure legibility and com-  
pleteness.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 60446

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-001  
D 60446

1-PLACE OF DEATH  
CITY OF BALTIMORE (NO. *Mercy Hospital 13* ST. *13* WARD)  
2-FULL NAME *Jesse H. Miller*  
(Residence in Baltimore: No. *3611 Cedar Ave.*)

REGISTERED No. C  
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
St. *8* yrs., *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*  
4-COLOR OR RACE *White*  
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*  
6-DATE OF BIRTH, *Sept. 22, 1893*  
(Month) (Day) (Year)  
7-AGE, *28* yrs. *3* mos. *26* ds.  
If LESS than 1 day, ... hrs. or ... min.  
8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *Brakeman*  
(b) General nature of industry, business, or establishment in which employed (or employer). *P. R. R.*  
9-BIRTHPLACE, (State or Country). *New Freedom Pa.*  
10-NAME OF FATHER, *Jesse H. Miller*  
11-BIRTHPLACE OF FATHER (State or Country). *Balt. Co. Md.*  
12-MAIDEN NAME OF MOTHER *Sarah Tracey*  
13-BIRTHPLACE OF MOTHER (State or Country). *Balt. Co. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant). *Mr. Sarah H. Miller*  
(Address). *3611 Cedar Ave.*

15-  
*Robert P. Harrison,*  
*191*  
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 17, 1922*  
(Month) (Day) (Year)  
17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry*  
(Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said *Inquiry*  
And that said deceased came to *his* death  
on the day stated above.  
The CAUSE OF DEATH was as follows:  
*Accident*  
*Multiple Fractures*  
(Duration) *8 hrs. 3 mos. 3 hrs*  
CONTRIBUTORY (Secondary) *Shock*  
(Duration) *83 blades*  
(Signed) *G. L. Brady* M. D.  
(Coroner)  
(Address) *1426 Broadway*  
\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).  
At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.  
Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Arundel Lodge* DATE OF BURIAL, *Jan. 20, 1922*  
20-UNDERTAKER, *Rorace H. Burke* ADDRESS *363 Falls Rd.*

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

D 60447

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 60447

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7416 N. Charles ST. WARD)

2-FULL NAME Frances J. Blair

(a) RESIDENCE NO. 7416 N. Charles WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas E Blair

6 DATE OF BIRTH (month, day, and year) Feb 8, 1840

7 AGE Years 81 Months 11 Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Jas Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Catherine Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant A. Eugene Blair (Address) 7416 N. Charles St

15 Robert F. HARRISON,

Filed 9/19/22 19 Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9, 1922

17 I HEREBY CERTIFY, That I attended deceased from January 16, 1922, to January 19, 1922, that I last saw her alive on January 18, 1922, and that death occurred, on the date stated above, at 9.30 m. The CAUSE OF DEATH\* was as follows:

Myocarditis

(duration) yrs. mos. ds. CONTRIBUTORY Cardiac decompensation (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted (if not at place of death)? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? (Signed) J. M. [Signature] M. D.

19 PLACED OF BURIAL, CREMATION OR RE- DATE OF BURIAL Greenmount Jan 11, 1922

20 UNDERTAKER Stm. Cook, 502 E North Ave



D 60448

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60448

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes Hospital* ST. *14* WARD)

## 2-FULL NAME

*Michael Moran*

(a) RESIDENCE NO.

*717 Mosher St.*

(Usual place of abode)

Length of residence in city or town where death occurred *50* yrs. mos. ds.

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*M.*

4 COLOR OR RACE

*W.*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*July 19 1860*

7 AGE

*62 yrs*

Years

Months

*6*

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Elevator Operator*

(b) General nature of industry, business, or establishment in which employed (or employer)

*086*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Ireland*

10 NAME OF FATHER

*Donot know*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Unknown*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Unknown*

14 Informant (Address)

*Oscar Kelley  
717 Mosher St.*

15

Filed

*Robert P. Harrison,*

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Jan 17 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Jan 17 1922* to *Jan 19 1922*, that I last saw *him* alive on *Jan 19 1922* and that death occurred, on the date stated above, at *11:30* m.

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*717 Mosher St.*

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*H. Harper*

M. D.

19 (Address)

*St. Agnes Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

*New Cathedral Jan 21 1922*

20 UNDERTAKER

ADDRESS

*William Beck 502 E Pratt*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Cause of Death is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60449

D 60449

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO

## 2-FULL NAME

(a) RESIDENCE. NO

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

18 mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

60449

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD)

WARD.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 29-1896

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

25

2

22

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Mate (Merchant Marine)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Merchant Marine

9 BIRTHPLACE (city or town) (State or country)

Annapolis Md.

10 NAME OF FATHER

John H. Brink.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

St Louis Mo.

12 MAIDEN NAME OF MOTHER

Rosa Basil.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Annapolis Md.

14 Informant (Address)

Hubert B. Mayo  
2015 N. Lafayette Ave

15

JAN 20 1922 ROBERT R. KRAUER Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

January 20 1922

17

I HEREBY CERTIFY, That I attended deceased from January 9<sup>th</sup> 1922, to January 20<sup>th</sup> 1922, that I last saw him alive on January 19 1922, and that death occurred, on the date stated above, at 12.45 a.m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis (General.)

(duration)

yrs.

22

ds.

CONTRIBUTORY (Secondary)

Septic (Auto-intoxication)

(duration)

yrs.

4

ds.

18 Where was disease contracted If not at place of death?

While in U. S. Navy.

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

at Johns Hopkins Hospital

(Signed)

George L. Shannon M. D.

1/24 1922 Address

700 Fulton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Annapolis Md.

January 20 1922

20 UNDERTAKER

Jas. S. Taylor Sons

ADDRESS

Annapolis Md.

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name use origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*This patient had been treated  
at Johns Hopkins Hospital  
where the diagnosis had  
been confirmed, and the  
case reported.*

*Reported from Hopkins as  
Pulmonary Tuberculosis. Meningeal*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60450

## CERTIFICATE OF DEATH.

REGISTERED NO. C

D 60450

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Sq. Hosp 19*)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *1303 W. Franklin St.*)St.: *40* yrs., *0* mos., *0* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*Male*

4-COLOR OR RACE,

*White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

*Single*

6-DATE OF BIRTH

*Feb - 15 - 1952*

(Month)

(Day)

(Year)

7-AGE,

*69 yrs. 10 mos. 4 ds.*

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Watchman*

9-BIRTHPLACE, (State or Country).

*Baltimore Md*

10-NAME OF FATHER,

*Arthur W. Wesson*

11-BIRTHPLACE OF FATHER (State or Country),

*Durham N.C.*

12-MAIDEN NAME OF MOTHER

*Min. Doeff*

13-BIRTHPLACE OF MOTHER (State or Country),

*Ukraine*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Charles Wilson*(Address) *2115 Wilkins Ave*

15-

Filed

*JAN 20 1922*

101

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH,

*Jun - 19 - 1922*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Jun 19 1922 to Jun 19 1922*that I saw him live on *Jun 19 1922*and that death occurred, on the date stated above, at *7:15 P.M.*

The CAUSE OF DEATH\* was as follows:

*Strangulated Hernia*(Duration) *7 yrs. 10 mos. 4 ds.*CONTRIBUTORY (Secondary) *Undermined Heart*(Duration) *12 yrs. 10 mos. 4 ds.*(Signed) *H. C. Wilson* M. D.(Address) *Franklin Sq. Hosp*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *7 yrs. 10 mos. 4 ds.* In the State *MD*Where was disease contracted, if not at place of death? *At Home*Former or usual residence *1303 W. Franklin St.*19-PLACE OF BURIAL OR REMOVAL, *London Park*20-UNDERTAKER *George J. Smith*DATE OF BURIAL *Jan. 23, 1922*ADDRESS *1000th Fayette St**H C Warlick MD*

important. See instructions on back of certificate.

D 60451

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60451

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Nursery Child's Hosp.

REGISTERED NO.

CITY OF BALTIMORE: (No.

Franklin &amp; Schroeder

ST.

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Leon Colomb Jr.

(a) RESIDENCE. NO.

Nursery Child's Hosp.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

1 yrs.

8 mos.

10 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year)

June 9 - 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

8

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Baby - 100

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

John Hopkins Hosp. Baltimore, Md.

10 NAME OF FATHER

Leon Colomb

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Vermont

12 MAIDEN NAME OF MOTHER

Esther Ruffing

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md.

14

Informant (Address)

Miss George A. Hutton 2 &amp; B Hospital

15

JAN 20 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 19 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 11 - 1922, to Jan 19 - 1922

that I last saw him alive on Jan 19 - 1922

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH\* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Nursery Child's Hosp.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Loral J. Pringle, M. D.

19 (Address) 1000 E. Pratt St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Rondo Park

Jan 20, 1922

20 UNDERTAKER

ADDRESS

George J. Smith

1000 W. Fayette St.

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior  
except acute bronchitis*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60452

## CERTIFICATE OF DEATH.

87 D 60452

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Home for Aged of the U. S.*)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Mrs Katharine Robinson*

## (a) RESIDENCE. No.

*400 N. Fulton Ave.*

## ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

*Lifetime*

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Widow*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Conway Robinson*

## 6 DATE OF BIRTH (month, day, and year)

*July 14-1844*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*76. 77**6**5*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Baltimore, Md.*

## 10 NAME OF FATHER

*Joseph King*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Penna.*

## 12 MAIDEN NAME OF MOTHER

*Katharine Sacron*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Penna.*

## 14

Informant (Address)

*Miss Etta Cuddy 400 N. Fulton Ave.*

## 15

Filed

19

*JAN 20 1922*

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*Jan 19 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from *Jan 15*, 19*22*, to *Jan 19*, 19*22*, that I last saw *her* alive on *Jan 17*, 19*22*, and that death occurred, on the date stated above, at *7.30 PM*.

The CAUSE OF DEATH\* was as follows:

*7.30 AM.**Bronchitis Acute*

(duration)

yrs.

mos.

ds.

## CONTRIBUTORY (Secondary)

*Pericarditis*

(duration)

yrs.

mos.

ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Jaundice*

(Signed)

*George C. Johnson*, M. D.

19

(Address)

*700 Fulton Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Western Cemetery**Jan 20, 1922*

## 20 UNDERTAKER

## ADDRESS

*George J. Smith**100 W. 2nd St.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60453

## CERTIFICATE OF DEATH.

113 D 60453

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

14 N. Pine

ST.: 4 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Duncan L. Devar

## (a) RESIDENCE. NO.

14 N Pine

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

M

## 4 COLOR OR RACE

W

## 5 Single, Married, Widowed, or Divorced (write the word)

—

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

—

## 6 DATE OF BIRTH (month, day, and year)

July 15/21

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

6

3

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

—

(b) General nature of industry, business, or establishment in which employed (or employer)

—

(c) Name of employer

—

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

Md.

## 10 NAME OF FATHER

Donald Devar

## 11 BIRTHPLACE OF FATHER (city or town)

Alexandria

(State or country)

Ontario Canada

## 12 MAIDEN NAME OF MOTHER

Eugene Stanford

## 13 BIRTHPLACE OF MOTHER (city or town)

Wichita

(State or country)

Ka

## 14

Informant (Address)

Donald Devar

14 N Pine St.

## 15

Filed

JAN 20 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan. 18, 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan. 17, 1922, to Jan. 18, 1922,

that I last saw him alive on Jan. 18, 1922,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Pneumonia - Pneumonia

(duration) yrs. mos. 3 da.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 da.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death?

Mr

Date of

Was there an autopsy?

Mr

What test confirmed diagnosis?

Clinical Exam

(Signed)

A. F. Rice

M. D.

Jan 19, 1922 (Address)

24 S. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL/CREMATION OR REMOVAL

## DATE OF BURIAL

St. Peter's Cemetery

Jan. 20

1922

## 20 UNDERTAKER

## ADDRESS

H. A. Hughes 424 S. Broadway



D 60454

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74 D 60454

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 Widdles ST. 17 WARD)

## 2-FULL NAME Elizabeth H. Wilcox

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE. NO. 517 Widdles ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband Dead

6 DATE OF BIRTH (month, day, and year) 4-8-88

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 74 yrs

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rochester N.Y.

10 NAME OF FATHER Wm Askins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Mass

12 MAIDEN NAME OF MOTHER Hester Askins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Mass

14

Informant Sarah Thompson

(Address) 855 E. Pratt St. Baltimore

15

Filed

JAN 20 1922

ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 10 1922, to Jan 17 1922, that I last saw him alive on Jan 17 1922, and that death occurred, on the date stated above, at 2:00 m.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage

CONTRIBUTORY (Secondary) Arteritis (duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. B. Bond M. D.

, 19 (Address) 3104 Walbrook Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laurel Cemetery Jan 19 1922

20 UNDERTAKER

ADDRESS

Mrs J. C. Locke 1302 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60455

## CERTIFICATE OF DEATH.

D 60455

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2025-Hargett Ave. ST., 9 WARD)

## 2. FULL NAME

Dorothy Kistner

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 2025-Hargett Ave. ST., 9 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Single6 DATE OF BIRTH (month, day, and year) 12-27-19217 AGE Years Months Days If LESS than 1 day, hrs. or min. 23

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None(b) General nature of industry, business, or establishment in which employed (or employer) Child.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) md.10 NAME OF FATHER George Kistner11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Julia Weiss13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)14 Informant George Kistner (Address) 2025-Hargett Ave.15 JAN 20 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 192217 I HEREBY CERTIFY, that I attended deceased from Jan. 15, 1922 to Jan 19, 1922 that I last saw her alive on Jan 19, 1922 and that death occurred, on the date stated above, at 8:17 m.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency(duration) yrs. mos. ds. 1 ds.CONTRIBUTORY Broncho-pneumonia (Secondary) (duration) yrs. mos. ds. 6 ds.18 Where was disease contracted if not at place of death? unknownDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? physical signs & symptoms(Signed) Samuel M. M. D., 19 (Address) 1506 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Mt. Carmel Cem.20 UNDERTAKER George J. Ruth ADDRESS 1735

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. PHYSICIANS should state EXACTLY.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Not congenital  
malformation. No  
history of any infectious  
disease.*



D 60456

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *708 E Egan* ST., *10* WARD)2-FULL NAME *Charles V Beck*(a) RESIDENCE NO. *708 Egan*

(Usual place of abode)

ST.,

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed,

or Divorced, (write the word)

*Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Nov 26 Nov 1920*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*1 2*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore City*  
(State or country)10 NAME OF FATHER *Charles V Beck*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Baltimore County*12 MAIDEN NAME OF MOTHER *Rose M. Krall*13 BIRTHPLACE OF MOTHER (city or town) *City*

(State or country)

14

Informant *Charles V Beck*(Address) *708 E Egan St*

15

Filed

19

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 18 1922*

17

HEREBY CERTIFY, That I attended deceased from  
*Jan 9 1922* to *Jan 18 1922*  
that I last saw him alive on *Jan 18 1922*and that death occurred, on the date stated above, at *6 P* m.

The CAUSE OF DEATH\* was as follows:

*Broncho Pneumonia*CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds. *19*

(duration)

yrs.

mos.

ds. *1*18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Edward J. Leary*

M. D.

1/19, 1922

(Address) *413 E Washington*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

*Holy Redeemer*

DATE OF BURIAL

*Jan 20 1922*

20 UNDERTAKER

ADDRESS

*Mr. Mrs. S. Link 1835 H Pratt*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 60457 HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. 24 WARD)

2-FULL NAME August F. Johnson

(a) RESIDENCE NO. US. Public Health Hosp. #56 ST.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored.

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

27 yrs.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Laborer

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Maryland

10 NAME OF FATHER

Harry Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

unknown

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

unknown

14

Informant  
(Address)

Edgar T. Rosenbrock. (Registrar)

15

JAN 20 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18, 1922

17

I HEREBY CERTIFY, That I attended deceased from  
Sept. 30, 1921 to Jan 18, 1922.

that I last saw him alive on Jan 18, 1922.

and that death occurred, on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH\* was as follows:

Tuberculosis chronic pulmonary far  
advance & active.

CONTRIBUTORY

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death? Unknown

Did an operation precede death? No

Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinic report.

(Signed)

1/18, 1922

Surgeon (P.)  
US. PHS Hosp. #56 Balto, Md.\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

National Cemetery

Jan 20, 1922

20 UNDERTAKER

ADDRESS

S. L. Lister &amp; Co. E. Balto, Md.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D. 60458

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 ~~W.~~ West

ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby E Hall

(a) RESIDENCE. No. 103 ~~W.~~ West

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 19 1922

7 AGE Years Months Days If LESS than 1 day, hrs. or min. Still Born

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER George Hall

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Helma McQuigg

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant George Hall (Address) 103 E West St

15 Filed JAN 20 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/19/22

17 I HEREBY CERTIFY, That I attended deceased from 1/19/22 to 1/19/22

that I last saw him alive on 1/19/22

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Premature birth (6 1/2 months gestation)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James Brown, M.D.

, 19 (Address) 1319 Light St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cedar Hill

1-20 1922

20 UNDERTAKER

Earl B. Harle

ADDRESS

115 E West St

D 60459

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60459

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal HospitalST. 76 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Heaps(a) RESIDENCE. NO. 55 Kinship Road  
(Usual place of abode)ST. 76 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced (write the word)

Widowed

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1837

7 AGE

84

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Housework

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Pennsylvania

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Unknown

14

Informant  
(Address)

Hospital Records,

Municipal Hospital.

15

JAN 20 1922

ROBERT R. KRAUTER,

Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18 19 22

17

I HEREBY CERTIFY, That I attended deceased from  
January 17, 19 22, to January 18, 19 22.  
that I last saw her alive on January 18, 19 22.  
and that death occurred, on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH\* was as follows:

Pneumonia

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
If not at place of death?

Did an operation precede death? 20 Date of

Was there an autopsy? 20

What test confirmed diagnosis?

(Signed)

J. M. D.

1/19/22 Address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Oak Lawn Cem  
J. Herwig & CoJan 21 19 22  
2008 Eileen

PHYSICIANS should state cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



Mar 0113

Spec. 6-9-19-H. P. Co. 1000 lks.

D 60460

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60460

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *914 N Carey* ST. *16* WARD)

2-FULL NAME

(a) RESIDENCE. No. *914 N Carey* ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *56* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug 7/1846*

7 AGE Years *75* Months *5* Days *12* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER *Jas. A. Gale*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *Mary Hedges*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

*JAN 20 1922*

ROBERT R. KRANTZ, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 19 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Oct 1921* to *Jan 19 1922*

that I last saw him alive on *Jan 18 1922*

and that death occurred, on the date stated above, at *5:00 a.m.*

The CAUSE OF DEATH\* was as follows:

*Sub-acute Bronchitis with Atelectasis*

CONTRIBUTORY (Secondary) *Failing heart & dropsy*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *E. J. Smith* M. D.

*19. 12* (Address) *1600 N. North Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*St. Mary's Cemetery* *Jan 21 1922*

20 UNDERTAKER ADDRESS

*Wm. J. Smith* *11. 1922*



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plauter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No other history*

60461

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1102 Warner* ST.: *21* WARD)

## 2-FULL NAME

*Robert Cornish*(a) RESIDENCE. No. *1102 Warner* ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *25* yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*male*

## 4 COLOR OR RACE

*Colored*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*1868*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*54*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Cook 021*

(b) General nature of industry, business, or establishment in which employed (or employer)

*on Schooner*

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Cambridge Maryland*

## 10 NAME OF FATHER

*John Cornish*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Cambridge Maryland*

## 12 MAIDEN NAME OF MOTHER

*Hester Campbell*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Cambridge Maryland*

## 14

Informant (Address)

*Jenia Purdy 1102 Warner St*

## 15

JAN 20 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan, 17, 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Dec, 31, 1921, to Jan, 17, 1922.*that I last saw him alive on *Jan, 16, 1922.*and that death occurred, on the date stated above, at *2.30 a, m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Endocarditis + Myocarditis*

(duration) yrs. mos. ds.

## CONTRIBUTORY

(Secondary) *Chronic Interstitial Nephritis*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *urine*(Signed) *Wm. Franklin*, M. D.1/18, 1922 Address) *in W. Lee St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

MT. AUBURN

## DATE OF BURIAL

*1.20. 22*

## 20 UNDERTAKER

R. L. PARHAM

649

## ADDRESS

W. Lee St

t

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Sp. 1-9-19-10 P. Co.—1000 Eks.

D 60462

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60462

CERTIFICATE OF DEATH.

1-PLACE OF DEATH / 98 Prospect Ave. Baltimore

REGISTERED NO.

CITY OF BALTIMORE: (No.

ST.

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Mildred Hare

(a) RESIDENCE. No. 198 Prospect Ave.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 11 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 5, 1908

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 13 11 16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Maryland

10 NAME OF FATHER Clarence R Hare

11 BIRTHPLACE OF FATHER (city or town) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Florence May Bell

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Maryland

14 Informant Clarence R Hare (Address) 198 Prospect Ave

15 JAN 20 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1922

17 I HEREBY CERTIFY, That I attended deceased from January 11<sup>th</sup>, 1922 to JAN. 18<sup>th</sup>, 1922, that I last saw him alive on JAN. 18<sup>th</sup>, 1922, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH\* was as follows: Pulmonary Tuberculosis

Approximately (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel Fargo, M. D. 19 (Address) 746 Dolphin St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Dried Ridge Jan 21 1922

20 UNDERTAKER ADDRESS

A S Marshall 3539 Falls Rd

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60463

## CERTIFICATE OF DEATH.

D 60463  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Home or Mt Vernon* St.; *25* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *Home or Mt Vernon* St.; *70* yrs.,  mos.  da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

1-SEX *Female* 4-COLOR *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH. *Unborn*, 18*42*  
(Month) (Day) (Year)

7-AGE. *80* yrs.  mos.  da. If LESS than 1 day,  hrs. or  min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *None*  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Ind*

10-NAME OF FATHER, *Unknown*

11-BIRTHPLACE OF FATHER (State or Country), *Ind*

12-MAIDEN NAME OF MOTHER *Sarah Williams*

13-BIRTHPLACE OF MOTHER (State or Country), *Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *George Corap*  
(Address) *Warren St. Mt Vernon*

15- *ROBERT R. KRAUTER,*  
JAN 20 1922 *Deputy Permit Clerk,*  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *1* *17*, 19*22*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *1* *12* 19*22*, to *1* *16* 19*22*, that I saw h *or* alive on *1* *16* 19*22*, and that death occurred, on the date stated above, at  m. The CAUSE OF DEATH\* was as follows:  
*Bronch. Pneumonia*

(Duration)  yrs. *5* mos. *5* da.  
CONTRIBUTORY *Cardiac Insufficiency*  
(Secondary)

(Duration)  yrs.  mos.  da.  
(Signed) *Thos B Hall* M. D.  
*1-18-1922* (Address) *Holbrook*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death  yrs.  mos.  da. In the  State  yrs.  mos.  da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Mt Vernon Ave* DATE OF BURIAL, *Jan 20 1922*

20-UNDERTAKER *Samuel Newby* ADDRESS *578*

important. See instructions on back of certificate.



60464

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60464

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 43 West ST. 23 WARD)2-FULL NAME Hannah Morissette(a) RESIDENCE. NO. 43 West ST. 23 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds.REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? 33 yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE Col5 Single, Married, Widowed, or Divorced (write the word) married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jerry Morissette6 DATE OF BIRTH (month, day, and year) 1/18/72

7 AGE

Years 50Months —Days —If LESS than 1 day, hrs. — or min. —

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic(b) General nature of industry, business, or establishment in which employed (or employer) General(c) Name of employer Housework9 BIRTHPLACE (city or town) (State or country) VA.10 NAME OF FATHER Samuel Wilkerson11 BIRTHPLACE OF FATHER (city or town) (State or country) VA.12 MAIDEN NAME OF MOTHER Martha Booker13 BIRTHPLACE OF MOTHER (city or town) (State or country) VA.

14

Informant

(Address) Linwood Wilkerson

15

Date

JAN 20 1922 ROBERT R. KRAUTER

Bureau Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/17/1922

17

I HEREBY CERTIFY, That I attended deceased from 8/38/21 to 1/17/22 that I last saw him alive on 1/16/22and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH\* was as follows:

Heart Regurgitation  
(duration) 6 yrs. 6 mos. — ds.  
CONTRIBUTORY Renal congestion  
(Secondary) about 6 yrs. 6 mos. — ds.18 Where was disease contracted none  
if not at place of death?Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? Clinical  
(Signed) Jerry Snoddy M. D.  
19 (Address) 908 S. Sharp St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laurel Jan 20 1922

20 UNDERTAKER

ADDRESS 1302John W. Henderson Emment

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 60465

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 60465

## CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Woman's Hospital* ST. *17* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Jan 18, 1922*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*

10 NAME OF FATHER

*William F. Dashiell*

11 BIRTHPLACE OF FATHER (city or town)

*Maryland*

(State or country)

12 MAIDEN NAME OF MOTHER

*Freda Lewis*

13 BIRTHPLACE OF MOTHER (city or town)

*Virginia*

(State or country)

14

Informant (Address)

*William F. Dashiell  
2020 Calvert St*

15

Filed

JAN 20 1922

ROBERT R. KRAUTER,  
Burial Permit Clerk,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Jan 9 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan 18, 1922* to *Jan 9, 1922*.that I last saw him alive on *Jan 19, 1922*.and that death occurred, on the date stated above, at *12:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Atelectasis of lungs*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Queen Anne's County Md.  
Wm. Cook**Jan 20 1922  
E. Hall*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important.

D 60466

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129D 60466

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1955 W. Franklin St. ST. 20 WARD)

## 2-FULL NAME

John Wesley Cameron

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1955 W. Franklin

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 10 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Ann Elizabeth Cameron

6 DATE OF BIRTH (month, day, and year) Oct. 11<sup>th</sup> 1846

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

75

3

8

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Smith Co.

Va.

## 10 NAME OF FATHER Daniel Cameron

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Va.

## 12 MAIDEN NAME OF MOTHER Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

## 14

Informant  
(Address)Mrs. Olie Dilley  
1955 W. Franklin St.

## 15

File

JAN 20 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19<sup>th</sup> 19 2217 I HEREBY CERTIFY That I attended deceased from  
Jan. 21, 19 22 to Jan 19, 19 22  
that I last saw him alive on Jan 18, 19 22

and that death occurred, on the date stated above, at 10.10 A.M.

The CAUSE OF DEATH\* was as follows:

Uremia

CONTRIBUTORY  
(Secondary)

(duration)

yrs. mos. ds.

(duration)

yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Jan. 19<sup>th</sup> 19 22 Address 400 N. Eager St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Cumberland Mt.

Jan. 20<sup>th</sup> 19 22

## 20 UNDERTAKER

## ADDRESS

Joseph B. Cook

4003 N. Eager St.

D 60467

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60467

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1610 N Registor* ST.: *8* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *August Westerhoff*(a) RESIDENCE. No. *1610 N. Registor* ST.,

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *42* yrs.

mos.

ds.

How long in U. S., if of foreign birth? *42* yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Male White Widower*

5a If married, widowed, or divorced

HUSBAND of

*late Eva Westerhoff*6 DATE OF BIRTH (month, day, and year) *Jan 1 - 1859*

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*63**—**17*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired**062*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Watchman*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Germany*

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Germany*

14

Informant

(Address)

*Elizabeth Lessner**1610 N Registor St.*

15

Filed

*JAN 20 1922*

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *January 18 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 10, 1922, to Jan 18, 1922,*that I last saw him alive on *Jan 18, 1922,*and that death occurred, on the date stated above, at *5:45 P. M.*

The CAUSE OF DEATH\* was as follows:

*R. Hemiplegia*(duration) yrs. mos. *8* ds.

CONTRIBUTORY (Secondary)

*Cerebral Hemorrhage*(duration) yrs. mos. *8* ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical*(Signed) *R. P. Carman* M. D.1-18-1922 Address *1707 N. Caroline St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Redeemer Jan 21 1922*

20 UNDERTAKER

ADDRESS *2016**Philip Seering Orleans St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

state should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. PHYSICIANS should be stated EXACTLY.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60468

## CERTIFICATE OF DEATH.

D 60468

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1819 Jefferson* ST.: *6* WARD)

## 2-FULL NAME

*Victoria Ruld Brown*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE, NO.

*1819 Jefferson*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *48* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Widow</i>
------------------------	---------------------------------	--

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sept 11 1853*7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*71 4 8*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House-wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Va.*10 NAME OF FATHER *Thos. H. Griffin*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Va.*12 MAIDEN NAME OF MOTHER *Maria*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Va.*14 Informant *Mamie R. Prunty* (Address) *1819 Jefferson St.*

201922

ROBERT R. KRAUTER  
Burial Permit Clerk.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan. 19 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan 15*, 1922, to *Jan 19*, 1922, that I last saw him alive on *Jan 18*, 1922, and that death occurred, on the date stated above, at *5a* la.

The CAUSE OF DEATH\* was as follows:

*Nephritis*(duration) *1* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Jacob Fisher*, M. D.  
*1/19/22* Address *1823 h. East St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Balto Cem.**Jan 21 1922*

20 UNDERTAKER

ADDRESS *2016**Philip Herwig**Oleans St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60469

## CERTIFICATE OF DEATH.

D 60469

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Druid Avenue ST. 14 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Archie Jackson

## (a) RESIDENCE, NO.

1622 Druid Avenue ST.

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

male

## 4 COLOR OR RACE

colored

## 5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Married

## 6 DATE OF BIRTH (month, day, and year)

March 1922

## 7 AGE

68

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home govt

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

md

## 10 NAME OF FATHER

Hubert

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

## 14

Informant

(Address)

Albert Jackson  
1622 Druid Avenue

## 15

Filed

JAN 20 1922

ROBERT R. KRAUTER,

Registrar

Burlat Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 - 1922

17

I HEREBY CERTIFY, That I attended deceased from

Dec 2, 1921, to Jan 19, 1922that I last saw him alive on Jan 19, 1922and that death occurred, on the date stated above, at 12:15 m.

The CAUSE OF DEATH\* was as follows:

Cardiac insufficiency(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

old age

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward J. Wheeler, M. D.1/9, 1922 Address: 238 S. 1st St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Laural CemeteryJan 21 1922

## 20 UNDERTAKER

## ADDRESS

John H. Todd142 White St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state EXACTLY.

D 60470

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60470

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5203 Elmore Ave. 77 WARD)

## 2-FULL NAME

Archie C. Lowe

## (a) RESIDENCE

No. 5203 Elmore Ave

(Usual place of abode)

Length of residence in city or town where death occurred

15 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Cauc

## 5 Single, Married, Widowed,

Married

6a If married, widowed, or divorced

HUSBAND of

Married

## 6 DATE OF BIRTH (month, day, and year)

Dec. 18, 1887

## 7 AGE

34 yrs

## Years

3

## Months

10

## Days

15

## If LESS than

1 day, hrs.

or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Real Estate agt.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

North Carolina

## 10 NAME OF FATHER

John Lowe

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

North Carolina

## 12 MAIDEN NAME OF MOTHER

unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

"

## 14

Informant (Address)

Fannie D. Lowe  
5203 Elmore Ave

## 15

Filed

JAN 20 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan. 18, 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan 17, 1922, to Jan 18, 1922.

That I last saw him alive on Jan 17, 1922.

and that death occurred, on the date stated above, at 3 A. M.

The CAUSE OF DEATH\* was as follows:

Acute Nephritis  
& Paralysis

(duration) yrs. mos. 3 ds.

## CONTRIBUTORY (Secondary)

Convulsions

(duration) yrs. mos. 1 ds.

## 18 Where was disease contracted

If not at place of death? At Home

Did an operation precede death? No Date of Jan 17

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) W D Wells M. D.

19 (Address) Wilmington

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Auburn Cem

## DATE OF BURIAL

Jan 22, 1922

## 20 UNDERTAKER

W. H. Holland

## ADDRESS

1631

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably such*, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No further history  
Cause of acute nephritis  
& paralysis unknown.*



D 60471

HEALTH DEPARTMENT—CITY OF BALTIMORE—D 60471

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 651 W Lafayette St WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annice Cook(a) RESIDENCE. NO. 651 W Lafayette St WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female Colored Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 12-18637 AGE 58 Years 9 Months 5 Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Housewife

9 BIRTHPLACE (city or town) (State or country)

VA

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant (Address)

Marceline D. Gray 651 W. Lafayette St

15

Filing

JAN 20 1922ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17-1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 12-1922, to Jan 17-1922.that I last saw her alive on Jan 16-1922.and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH\* was as follows:

Coronary Hemorrhage(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? XDid an operation precede death? no Date of XWas there an autopsy? +

What test confirmed diagnosis?

(Signed) J. Ven Williams M. D.19 (Address) 601 Cassell St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Int. Auburn City Jan 20 1922

20 UNDERTAKER

ADDRESS

George B. Holland 1631 Druid Hill Ave

D 60472

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60472

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.: *XIII* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. *Ellicott City Md* ST.: *9* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mrs Elizabeth Leake*6 DATE OF BIRTH (month, day, and year) *Dec. 7-73*7 AGE Years *48* Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Insurance*(b) General nature of industry, business, or establishment in which employed (or employer) *1886*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Md.*10 NAME OF FATHER *Joseph Leake*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md.*12 MAIDEN NAME OF MOTHER *Sarah Hunt*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*

14

Informant (Address) *Mercy Hospital Records*

15

JAN 20 1922 ROBERT H. KRAUTER, Registrar Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 20 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan 11 1922* to *Jan 20 1922* that I last saw him alive on *Jan 20 1922* and that death occurred, on the date stated above, at *11:30 a. m.*

The CAUSE OF DEATH\* was as follows:

*Perforated duodenal ulcer (General Peritonitis)*

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *yes* Date of *Jan 11 1922*Was there an autopsy? *yes*What test confirmed diagnosis? *Signs of peritonitis*(Signed) *Wm. J. Brown M. D.*19 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Ellicott City**Jan 22 1922*

20 UNDERTAKER

ADDRESS

*Scott M. Starr**Ellicott City*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60473

## CERTIFICATE OF DEATH.

REGISTERED NO. C

D 60473

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin St. Hospital* St. *19* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *1319 Edmondson Ave* St. *54* yrs., *1* mos., *12* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*6-DATE OF BIRTH. *Nov* *27*, *1867*  
(Month) (Day) (Year)7-AGE. *54* yrs., *1* mos., *12* ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *109*  
(b) General nature of industry, business, or establishment in which employed (or employer). *Black*9-BIRTHPLACE, (State or Country), *Ind.*10-NAME OF FATHER, *Samuel Ebaugh*11-BIRTHPLACE OF FATHER (State or Country), *Ind.*12-MAIDEN NAME OF MOTHER *Sarah Rowble*13-BIRTHPLACE OF MOTHER (State or Country), *Ind.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss Elizabeth Ebaugh*(Address) *1319 Edmondson Ave*15-*JAN 20 1922* 191. ROBERT R. KRAUTER,  
Filed Registrar.Burial Permit No. *101*

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan* *19*, *1922* *191*...  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 24* 1912, to *Jan* *19* 1912, that I saw him alive on *Jan* *19* 1912, and that death occurred, on the date stated above, at *4:20 P.m.*

The CAUSE OF DEATH\* was as follows:

*T.B.C. 8-9-10 dorsal vertebrae**with osseous structure*

.....

.....

..... (Duration) ..... yrs. *18* mos. .... ds.CONTRIBUTORY *Paralysis from virus*  
(Secondary) .......... (Duration) ..... yrs. *10* mos. .... ds.(Signed) *Newton S. Parr* M. D......, 191... (Address) *Franklin St. Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. *4* mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence *1319 Edmondson Ave*

## 19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*Wesley Chapel* *Jan 22, 1922*20-UNDERTAKER *Wm. R. R. R.* ADDRESS *2238 N. Mt. St.*

D 60474

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60474

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *46 E. T. Barney*ST. *23* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Edna Mary Hamilton*(a) RESIDENCE, NO. *46 E. T. Barney*

ST. WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Jan. 1, 1918*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*4**0**19*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balto. Ind*

10 NAME OF FATHER

*Edw. J. Hamilton*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balto. Ind.*

12 MAIDEN NAME OF MOTHER

*Anna Edlin*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balto. Ind.*

14

Informant (Address)

*Edw. J. Hamilton. 46 E. T. Barney.*

15

JAN 20 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Jan. 19 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 18 1922, to Jan 19 1922, that I last saw her alive on Jan 19 1922,*and that death occurred, on the date stated above, at *9.30 P. m.*

The CAUSE OF DEATH\* was as follows:

*Diphtheria*(duration) yrs. mos. *2* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Wm. I. Seabury* M. D.1/19, 1922 (Address) *638 Fair Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Edna Mary Hamilton**Jan 20 1922*

20 UNDERTAKER

ADDRESS

*Geo. H. Schwab*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60475

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (NO. *St. Agnes Hosp*)ST. *20* WARD

## 2. FULL NAME

(a) RESIDENCE NO. *2426 Fredk Road*

(Usual place of abode)

ST. *20* WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *69* yrs.

mos.

ds.

How long in U. S., if of foreign birth? *69* yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*4 COLOR OR RACE *W*5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced, HUSBAND of (or) WIFE of *Joseph Schaffer*6 DATE OF BIRTH (month, day, and year) *Oct. 12-1852*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. *69 yrs 3 mos 7 ds*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Not any*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Maryland*10 NAME OF FATHER *William Butcher*11 BIRTHPLACE OF FATHER (city or town) (State or country) *" "*12 MAIDEN NAME OF MOTHER *Emma Connyell*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Maryland*

14

Informant (Address) *Mrs Picella Reinhardt 2426 Fredk Road*

15

JAN 20 1922

ROBERT R. KRAU

Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan. 19 1922*

17

HEREBY CERTIFY, That I attended deceased from *Jan 13*, 19 *22*, to *Jan 19*, 19 *22*, that I last saw him alive on *Jan 19*, 19 *22*, at *7:30 P.M.*

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

*Lobular Pneumonia*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *2426 Fredk Road*

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *H. Harper*

M. D.

, 19

(Address) *St Agnes Hospital*

\*State the Disease Causing Death, in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
(MOVAL) *London Park*

DATE OF BURIAL

20 UNDERTAKER *George Schmitt*ADDRESS *201 E. E. Ave*

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60476

## CERTIFICATE OF DEATH.

D 60476

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 E. Monument St. 10

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Infant of Rebecca David Greenfield

## (a) RESIDENCE. NO. 1424 E. Monument St.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

m

## 4 COLOR OR RACE

white

## 5 Single, Married, Widowed, or Divorced (write the word)

single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Jan 19 - 1922

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

## 10 NAME OF FATHER

David Greenfield

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

## 12 MAIDEN NAME OF MOTHER

Rebecca Lerner

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

## 14

Informant (Address)

David Greenfield 1424 E. Monument St.

## 15

Filed

19

Registrar

JAN 20 1922

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan 20 1922

## 17

HEREBY CERTIFY, That I attended deceased from

Jan 19 1922 to Jan 19 1922

that I last saw him alive on Jan 19 1922

and that death occurred, on the date stated above, at 9 9 m.

The CAUSE OF DEATH\* was as follows:

Cerebral Compression due to Pelvic Distortion

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert H. Levy M. D.

(Address) 1424 E. Monument St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Hebrew Burial Bur Jan 20 1922

## 20 UNDERTAKER

## ADDRESS

S. Simpson &amp; Bro E. Belts

D 60477

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60477

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.: *4* WARD)2-FULL NAME *Silas H. Hunter M.D.*(a) RESIDENCE. NO. *Porter, Balto. 20, Md.* ST. *1* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *22* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mrs. Sarah Hunter*6 DATE OF BIRTH (month, day, and year) *Apr. 29, 1884*7 AGE Years *32* Months *8* Days *21* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Md.*10 NAME OF FATHER *P. H. Hunter*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md.*12 MAIDEN NAME OF MOTHER *Margaret Hughes*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*14 Informant *Hospit Record* (Address):15 *JAN 20 1922* ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan, 19 1922*

17 I HEREBY CERTIFY, That I attended deceased from

*Dec 27, 1921*, to *Jan 19, 1922*that I last saw him alive on *Jan 19, 1922*and that death occurred, on the date stated above, at *5:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of stomach (inoperable)*  
(duration) *1* yrs. *1* mos. *1* ds.CONTRIBUTORY (Secondary) *Carcinoma*  
(duration) *1* yrs. *1* mos. *1* ds.18 Where was disease contracted *Home*  
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *Autopsy*(Signed) *Wm. C. Ewing, M. D.*19 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Greenmount Cem* *1/21/22*

20 UNDERTAKER ADDRESS

*Edw. J. Fulton* *Myrtle*

60478

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 S Hurley ST., 1 WARD)

## 2-FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

50 yrs.

mos.

How long in U. S., if of foreign birth?

50 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Rex Gampini

6 DATE OF BIRTH (month, day, and year)

Aug 5 1857

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

64

5

14

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House keeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Italy

10 NAME OF FATHER

Frank Ambrosi

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

12 MAIDEN NAME OF MOTHER

Ida Bolotsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Italy

14

Informant (Address)

Josephine Rezo 523 S Hurley

15

Filed JAN 20 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 18 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 1 1922 to Jan 18 1922.

that I last saw him alive on Jan 18 1922.

and that death occurred, on the date stated above, at 11.4 a.m.

The CAUSE OF DEATH\* was as follows:

Heptic Carcinoma

(duration) yrs. 1 mos. 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Valentini M. D.

Jan 20 1922 (Address) 22 Bond

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Redeemer

DATE OF BURIAL

January 21 1922

20 UNDERTAKER

Wendell Duffel &amp; Son

ADDRESS

378 N. Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60479

## CERTIFICATE OF DEATH.

D 60479

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Bolton

ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary S. Corbin

(a) RESIDENCE. No. 1416 Bolton

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Charles W. Corbin

6 DATE OF BIRTH (month, day, and year) Dec. 3, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	1	17	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Northampton Co.,  
(State or country) Va.

10 NAME OF FATHER Dr. Geo. W. Smith

11 BIRTHPLACE OF FATHER (city or town) Virginia  
(State or country)

12 MAIDEN NAME OF MOTHER Emily W. Nottingham

13 BIRTHPLACE OF MOTHER (city or town) Virginia  
(State or country)14 Informant Charles S. Corbin  
(Address) 1416 Bolton Street15 JAN 20 1922 ROBERT R. KRAUTER  
Registrar  
Burial Permit Clerk.

Via B. C. &amp; A. Railway Co. s boat.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19 1922

17 I HEREBY CERTIFY, That I attended deceased from

Dec 1, 1921, to Jan 11, 1922,

that I last saw her alive on Jan 11, 1922,

and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH\* was as follows:

Cancer of the breast

(duration) about 2 yrs. mos. ds.

CONTRIBUTORY General metastases  
(Secondary) about

(duration) about 6 yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? yes Date of July 1921

Was there an autopsy? no

What test confirmed diagnosis? operation  
(Signed) Arthur L. Bloomfield, M. D.

19 (Address) 1107 St Paul St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Onancock, Va.

1/20, 1922

20 UNDERTAKER

ADDRESS

Henry W. Mears &amp; Son 805 N. Calvert

Charles S. Corbin, Escort

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY.

very  
PHYSICIANS should  
EXACTLY. Exact statement of OCCUPATION  
AGE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION  
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60480

CERTIFICATE OF DEATH.

100 D 60480

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1008 W Lexington St.: 18 WARD)

2-FULL NAME

Glover Collins

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 19.)

(Residence in Baltimore: No. 1008 W Lexington St.: yrs., 3 mos. 7 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

June 1, 1918 (Month) (Day) (Year)

7-AGE,

3 yrs., 7 mos., 18 da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Balt City

10-NAME OF FATHER,

Thomas Collins

11-BIRTHPLACE OF FATHER

(State or Country),

Balt, Md,

12-MAIDEN NAME OF MOTHER

Helen Syle

13-BIRTHPLACE OF MOTHER

(State or Country),

Balt, Md,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Collins

(Address) 1008 W Lexington

15-

Robert P. Harrison,

Funeral Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan 18, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Branch Pneumonia

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

Acute Bronchitis

(Duration) yrs. mos. da.

(Signed) James M. Harrison, M. D. (Coroner.)

Jan 18, 1922 (Address) 700 E. Charles

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. da. State... yrs. mos. da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

St. Ambrose

Jan 23, 1922

20-UNDERTAKER

ADDRESS

Samuel H. ...

...

D 60481

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60481

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rodger brookins(a) RESIDENCE. No. 6 N. Stockin st.ST. 18 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

45

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Staved ore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Virginia

10 NAME OF FATHER Rodger Brookins11 BIRTHPLACE OF FATHER (city or town) Richmond

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER Susan ??

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia

14

Informant  
(Address)

Hospital Records

Robert H. Harrison,

15

Filed

19

Burial Permit Clerk,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18, 19 22

17

I HEREBY CERTIFY, That I attended deceased from  
October 24, 19 21, to Jan. 18, 19 22that I last saw him alive on Jan. 17, 19 22and that death occurred, on the date stated above, at 12.30 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 3 mos. ds.CONTRIBUTORY Hemorrhage  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Unknown

Did an operation precede death?

No

Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed)

Francis D. Bader, M. D.

1-18-22 Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn

Jul 22 1922

20 UNDERTAKER

ADDRESS

Dean Hopkins

Pe an

Every item of information should be stated EXACTLY. PHYSICIANS should state exact statement of O.C.U.P.A. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.





D 60483

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 338 P. Clement ST. 24 WARD)

## 2-FULL NAME

(a) RESIDENCE. NO. 338 P. Clement ST. 24 WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Robert V. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 17, 1922, to Jan 22, 1922

that I last saw him alive on Jan 22, 1922

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH\* was as follows:

Coronary Thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Harrison, M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

201922

Burial Permit Clerk.

D 60484

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60484

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *814 China*)2-FULL NAME *Ida Coby*(a) RESIDENCE, No. *814 China*

(Usual place of abode)

Length of residence in city or town where death occurred *11* yrs. mos. ds.ST. *132*

WARD.

REGISTERED No. *101-001*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If nonresident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed or divorced HUSBAND of (or) WIFE of *James Coby*6 DATE OF BIRTH (month, day, and year) *Autumn 1893*7 AGE Years *28* Months — Days — If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Domestic*(b) General nature of industry, business, or establishment in which employed (or employer) *Cook*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Md.*10 NAME OF FATHER *Thos. Purroy*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md.*12 MAIDEN NAME OF MOTHER *Harriet Jones*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*14 Informant *Lily Brooks* (Address) *836 1/2 Eutaw St*15 Filed *Robert P. Harrison,*

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *1/19/22*17 I HEREBY CERTIFY, That I attended deceased from *1/7/22* to *1/19/22* that I last saw him alive on *1/18/22* and that death occurred, on the date stated above, at *3:15 a.m.*

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*

CONTRIBUTORY (Secondary)

*Ac. Bronchitis* (duration) *about 3* yrs. mos. ds. *about 8* yrs. mos. ds.18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical*(Signed) *J. H. Burley* M. D. (Address) *908 S Sharp St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Duke Mt Ind Calvert County* *4/21* 1922

20 UNDERTAKER ADDRESS

*Mrs. Geo H. Hooper* *406 M. Conroy*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N 8 01922

D 60485

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60485

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1831 Hanover* ST. *73* WARD)2-FULL NAME *Margaret M. Earl*(a) RESIDENCE. NO. *1831 Hanover* ST. *73* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*F*

4 COLOR OR RACE

*W*

5 Single, Married, Widowed, Divorced (write the word)

*Married*

5a If married, widowed, or divorced

(or) WIFE of *Frank Earl*6 DATE OF BIRTH (month, day, and year) *— 1867*

7 AGE

Years

Months

Days

If LESS than  
1 day, — hrs.  
or — min.*53*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Clerk 137*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *W.D.*10 NAME OF FATHER *Harry Russell*11 BIRTHPLACE OF FATHER (city or town) (State or country) *W.D.*12 MAIDEN NAME OF MOTHER *Matilda*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *W.D.*

14

Informant (Address) *Frank Earl 1831 Hanover St.*

15

Filed

*Robert P. Harrison,*

Registrar

N 2 01922

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 19 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 17, 1922, to Jan 19, 1922*that I last saw him live on *Jan 19, 1922*and that death occurred, on the date stated above, at *8 A. M.*

The CAUSE OF DEATH\* was as follows:

*Mitral Insufficiency**Indefinite*  
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Acute Dilatation of Heart*  
(duration) yrs. mos. ds. *2*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinically*(Signed) *R. H. Campbell* M. D.*Jan 20, 1922* (Address) *1644 Hanover St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Calvary Hill* *1/21/22*

20 UNDERTAKER

ADDRESS

*W. J. Vandersone* *1318 Light*

D 60486

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60486

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1015 Valley* ST. *10* WARD)

## 2-FULL NAME

(a) RESIDENCE. No. *1015 Valley* ST. *10* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *65* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (Write the word)

5a If married, widowed, or divorced

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

PARENTS

14 Informant

(Address)

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *1/19* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

*Dec 13* 19 *21*, to *1/19* 19 *22*.that I last saw him alive on *1-19* 19 *22*.and that death occurred, on the date stated above, at *9:45* a. m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma Stomach*(duration) yrs. *3* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *Teuino analysis*

(Signed)

190177 (Address) *914 E. Broadway*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cathedral Cemetery**1/21* 19 *22*

20 UNDERTAKER

ADDRESS

*J. J. Doherty**1318 Light St*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

N2 01922





D 60488

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60488

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *618 Eislens* ST. *22* WARD)

## 2-FULL NAME

*Susan Turner*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE. NO.

*618 Eislens*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

*72* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*John Turner*

6 DATE OF BIRTH (month, day, and year)

*1849*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*72*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

*037*

(c) Name of employer

9 BIRTHPLACE (city or town). (State or country)

*Maryland*

10 NAME OF FATHER

*Chas. Stanley*

11 BIRTHPLACE OF FATHER (city or town). (State or country)

*md*

12 MAIDEN NAME OF MOTHER

*Matilda*

13 BIRTHPLACE OF MOTHER (city or town). (State or country)

*md*

14

Informant (Address)

*John Turner 618 Eislens St*

15

Filed

*Robert F. Harrison,*

19

Registrar

N 81 1922

Serial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 19* 19 *22*

17 I HEREBY CERTIFY, That I attended deceased from

*Jan 1* 19 *22*, to *Jan 19* 19 *22*.that I last saw her alive on *Jan 18* 19 *22*.and that death occurred, on the date stated above, at *4.30 P.* m.

The CAUSE OF DEATH\* was as follows:

*Quintipia's Arterial Remedy*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

*as Turner*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

*618 Eislens*Did an operation precede death? *No* Date ofWas there an autopsy? *x*

What test confirmed diagnosis?

*Charachester Symples*

(Signed)

*C. F. Harrison, M. D.*

19 22 Address)

*714 S. B. St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mt Auburn**Jan 22* 19 *22*

20 UNDERTAKER

ADDRESS

*John H. Toadwin**142 W. Hill St*

Spec.—1-10-21—M&T—1500 Bks.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60489

## CERTIFICATE OF DEATH.

179 D 60489

1-PLACE OF DEATH *Hebrew Hospital*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST., *13* WARD)

2-FULL NAME *Mrs Betty Weil*

(a) RESIDENCE NO. *2538 Madison Ave*

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *2 yrs* mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F.* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *unknown 1836*

7 AGE *65* Year: Months: Days: If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House work*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md.* (State or country)

10 NAME OF FATHER *Richard*

11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)

12 MAIDEN NAME OF MOTHER *Amelia Rosenheim*

13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)

14 Informant *Sarah Rosenheim* (Address) *2538 Madison Ave*

15 *Robert P. Harrison,*

Registrar

Serial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 20 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Dec 24 1921* to *Jan 19 1922*

that I last saw her alive on *Jan 19 1922*

and that death occurred, on the date stated above, at *10 45 Am.*

The CAUSE OF DEATH\* was as follows:

*Bronchopneumonia  
Arterial Sclerosis*

(duration) *0* yrs. *0* mos. *16* ds.

CONTRIBUTORY *Ch. Nephritis, Hypertension* (Secondary)

*Arterio Sclerosis* (duration) *many yrs.* mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *yes*

What test confirmed diagnosis?

(Signed) *Rosenheim* M. D.

*1/18, 1922* (Address) *Hebrew Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Hebrew Menorah*

*Jan 22 1922*

20 UNDERTAKER

ADDRESS

*J. Ahrens & Co*

*1611 Mad Ave*

D 60490 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60490

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *4 Josephine Hospital* ST. *40* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

## (a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## WARD.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed,

*Married*

or Divorced (write the word)

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Jan 28 1912*

## 7 AGE

Years

Months

Days

If LESS than

1 day *12* hrs.

or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Balt. Md*

## 10 NAME OF FATHER

*Frederick Bergmann*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Balt. Md*

## 12 MAIDEN NAME OF MOTHER

*Lillian M. Schaefer*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Balt. Md*

## 14

Informant  
(Address)*Mr. Frederick Bergmann  
934 E. Biddle*

JAN 21 1922

Robert P. Harrist, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*1/20/1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*1/20/1922* to *1/20/1922*that I last saw her alive on *Jan 20/1922*and that death occurred, on the date stated above, at *5 P* m.

The CAUSE OF DEATH\* was as follows:

*Asphyxia Neonatorum*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *P. Signis*(Signed) *Bernard Weiss* M. D.

934 E. Biddle

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Holy Redeemer Church Jan 21 1922*

## 20 UNDERTAKER

## ADDRESS

*Henry Hooker Son 1301 E. Bay*



D 60491

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60491

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Howard A. Kelly Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.: 14 WARD)

2-FULL NAME

Mary M. Campbell

(a) RESIDENCE. No.

Johnstown Pa.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 20 / 1882

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

25 63.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pittsburgh Pa.

10 NAME OF FATHER

Camp. Frank Robb

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Pittsburgh Pa.

12 MAIDEN NAME OF MOTHER

Mary M. Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Johnstown Pa.

14

Informant (Address)

Charles Campbell, Johnstown Pa.

15

Filed

Robert P. Harrison, Registrar

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 20 1922

17

I HEREBY CERTIFY, That I attended deceased from

19

Jan 20 1922

that I last saw h. alive on Jan 20 1922

and that death occurred, on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH\* was as follows:

Acute nephritis - post-operative

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

1 1/2

(duration)

yrs.

mos.

1 1/2

18 Where was disease contracted if not at place of death?

✓

Did an operation precede death?

Yes

Date of

Jan 17, 1922

Was there an autopsy?

No

What test confirmed diagnosis?

None

(Signed)

Arthur C. Brumrose, M. D.

1/21, 1922 (Address)

1418 Canton Place

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Johnstown Pa.

Jan 21 1922

20 UNDERTAKER

ADDRESS

Wm. Cook

502 E. North Ave.

JAN 21 1922

Burial Permit Clerk.]

PHYSICIAN should state EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Operation for gallstones*  
*No cancer.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60492

D 60492

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3627 Greenmount Ave. WARD 9)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Alta E. Mullikin*

(a) RESIDENCE No. 3627 Greenmount Ave. WARD 9

(Usual place of abode)

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth *Life* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*5a If married, widowed, or divorced, HUSBAND of *Richard T. Mullikin* (or) WIFE of *Alta E. Mullikin*6 DATE OF BIRTH (month, day, and year) *July 22*7 AGE Years *63* Months *11* Days *11* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Md.*10 NAME OF FATHER *J. M. J. Rhodes*11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country) *Md.*12 MAIDEN NAME OF MOTHER *Margaret E. Rhodes*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country) *Md.*14 Informant *Mrs. Mary R. Porsal* (Address) *3627 Greenmount Ave.*15 *Robert P. Harrison* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 19 1922*17 I HEREBY CERTIFY, that I attended deceased from *July 17, 1922* to *Jan 19, 1922*, that I last saw him alive on *Jan 19, 1922* and that death occurred, on the date stated above, at *9:30* m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis*  
(duration) *20* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Typical Bacteria*(Signed) *Allen Thomas* M. D.(Address) *1228 N. Caroline*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

*Greenmount Ave. Jan 24 1922*

UNDERTAKER ADDRESS

*William L. Baker & Son*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

No. 1

1922

Do. Thomas R. Harrison



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60493

## CERTIFICATE OF DEATH.

138 D 60493  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin St. Hopkin* ST.; *27* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*Bertha E. France*(Residence in Baltimore: No. *5151 Park Heights* St.; *86* yrs., *inca.* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE

*White*

## 5-SINGLE, WIDOWED, OR DIVORCED, (Write the word)

*Married*

## 6-DATE OF BIRTH

*12* (Month) *16* (Day), *1886* (Year)

## 7-AGE

*35* yrs., *1* mos., *2* ds.

## IF LESS than 1 day,

...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*Housewife*

## 9-BIRTHPLACE (State or Country)

*Westminster Md*

## 10-NAME OF FATHER

*James H. Hook*

## 11-BIRTHPLACE OF FATHER (State or Country)

*Maryland*

## 12-MAIDEN NAME OF MOTHER

*Elizabeth Deane*

## 13-BIRTHPLACE OF MOTHER (State or Country)

*Maryland*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

*Samuel H. France*  
*5151 Park Heights*

## 15-

Filed *Robert B. Harrison*

Registrar

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*1* (Month) *19* (Day), *1922* (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*1-14-1922*, to *1-19-1922*,that I saw her alive on *1922*,and that death occurred, on the date stated above, at *5 P.* m.

The CAUSE OF DEATH\* was as follows:

*Acute Pericarditis*(Duration) *20* yrs., *20* mos., *20* ds.

## CONTRIBUTORY (Secondary)

(Duration) *6* yrs., *6* mos., *6* ds.(Signed) *W. J. Parn* M. D.*1-20*, 1922 (Address) *Franklin St. Hopkin*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *5* yrs., *5* mos., *5* ds. In the State *5* yrs., *5* mos., *5* ds.Where was disease contracted, if not at place of death? *5151 Park Heights*Former or usual residence *5151 Park Heights*

## 19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

*Deer Park* *1-22-1922*

## 20-UNDERTAKER

*William Corb*

## ADDRESS

*502 E. North*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in very important. See instructions on back of certificate.

1922 Burial Permit (10K)



Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Southwell)  
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60494

CERTIFICATE OF DEATH.

10 D 60494

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3705 Eastern Ave ST. 76 WARD)

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aida Southwell

(a) RESIDENCE. No. 3705 Eastern Ave ST. WARD.  
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 4 mos. 14 ds. How long in U. S., if of foreign birth?

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 6/1919

7 AGE Years 2 Months 4 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

10 NAME OF FATHER Roy Clifton Southwell

11 BIRTHPLACE OF FATHER (city or town) Perry Michigan (State or country)

12 MAIDEN NAME OF MOTHER Mabel Margaret Nelson

13 BIRTHPLACE OF MOTHER (city or town) London Canada (State or country)

14 Informant Mrs Roy Clifton Southwell (Address) 3705 Eastern Ave

15 Filed Robert P. Harrison, Registrar

N 21 1922

Serial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1922, to Jan 20, 1922, that I last saw her alive on Jan 20, 1922, and that death occurred, on the date stated above, 2 P m. The CAUSE OF DEATH\* was as follows:

Diphtheria

(duration) yrs. mos. 3 ds. CONTRIBUTORY Cardiac Asthenia (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Positive culture (Signed) Walter W White Jr M. D. 1/20/1922 (Address) 2800 St Paul St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL London Park Cemetery Jan 21 1922

20 UNDERTAKER ADDRESS Henry N Amos 4204 Ridgewood Ave

Spec. -1-10-21-M&T-1500 Rks.  
D 60495 HEALTH DEPARTMENT-CITY OF BALTIMORE D 60495  
CERTIFICATE OF DEATH.  
1-PLACE OF DEATH  
CITY OF BALTIMORE: (No. 514 Oakland ave ST. 27 WARD)  
2-FULL NAME Susanna Jones.  
(a) RESIDENCE No. 514 Oakland ave ST. WARD  
(Usual place of abode)  
Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.  
PERSONAL AND STATISTICAL PARTICULARS  
3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow  
5a If married, widowed, or divorced HUSBAND of John W Jones. (or) WIFE of  
6 DATE OF BIRTH (month, day, and year) June 30 1849  
7 AGE Years 72. Months 6 Days 19 If LESS than 1 day, hrs. or min.  
8 OCCUPATION OF DECEASED  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer  
9 BIRTHPLACE (city or town) Baltimore (State or country) Md.  
10 NAME OF FATHER Wm Jamieson  
11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland  
12 MAIDEN NAME OF MOTHER Marjorie Cannon  
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rochester Co Md.  
14 Informant Ella E Gouse (Address) 514 Oakland ave  
15 Robert P. Harrison, Registrar  
Burial Permit Clerk.  
JAN 21 1922  
179  
REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)  
(If non-resident give city or town and State)  
MEDICAL CERTIFICATE OF DEATH  
16 DATE OF DEATH (month, day, and year) Jan. 19 1922  
17 I HEREBY CERTIFY, That I attended deceased from Jan. 5 1922, to Jan. 19 1922, that I last saw her alive on Jan. 18 1922, and that death occurred, on the date stated above, at 2 A. m.  
The CAUSE OF DEATH\* was as follows:  
Cerebro Sclerosis  
(duration) 6 yrs. mos. ds.  
CONTRIBUTORY Cause Intestinal Nephritis (Secondary) (duration) yrs. mos. ds.  
18 Where was disease contracted If not at place of death?  
Did an operation precede death? no Date of  
Was there an autopsy? no  
What test confirmed diagnosis? Clinical  
(Signed) J B C House, M. D.  
1-15 1922 (Address) 5600 York Rd.  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)  
19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Druid Ridge Jan 21 1922  
20 UNDER TAKER John O. Mitchell 1201 W. Fayette St. ADDRESS

JAN 21 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60496

D 60496

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland General Hospital* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*George E Myers*

## (a) RESIDENCE. NO.

*720 N. Gilmore St.*

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *67* yrs. *9* mos. *15* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced (write the word)

*married*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Sadie Myers*

## 6 DATE OF BIRTH (month, day, and year)

*April 15, 1854*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*67**9**15*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Officer in Bank*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Maryland*

## 10 NAME OF FATHER

*Robert Myers*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Maryland*

## 12 MAIDEN NAME OF MOTHER

*Lidia Ennis*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Maryland*

## 14

Informant (Address)

*Sarah A. Myers  
720 N. Gilmore St.*

## 15

Filed

*Robert P. Harrison, Registrar*

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*Jan. 20, 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*Jan 16, 1922, to Jan 20, 1922*

that I last saw him alive on

*Jan 20, 1922*and that death occurred, on the date stated above, at *7.07 A.M.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of the Head of the Pancreas, involving the Post-Portion of Lymphatic Glands.*

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

*Cardiac Failure*

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

*720 N. Gilmore St.*

Did an operation precede death?

*Yes Date of Jan. 19, 1922*

Was there an autopsy?

What test confirmed diagnosis?

*Clinical*

(Signed)

*John W. Metcalf, M.D.*

## 19

(Address)

*Md. General Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Louden Park Jan 23, 1922*

## 20 UNDERTAKER

## ADDRESS

*John Mitchell & Co. 1201 N. Fayette St.*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N 9 1 1922

D 60497

HEALTH DEPARTMENT—CITY OF BALTIMORE

60497

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *3407 Clairmont* ST., *26* WARD)

## 2. FULL NAME

(a) RESIDENCE NO. *3407 Clairmont* ST.,

(Usual place of abode)

Length of residence in city or town where death occurred *40* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mary Wolf*6 DATE OF BIRTH (month, day, and year) *Oct 11-1891*7 AGE Years *30* Months *3* Days *12* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Labourer*(b) General nature of industry, business, or establishment in which employed (or employer) *Retired*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *John Wolf*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Don't know*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14

Informant (Address) *Mary Wolf 3407 Clairmont**Robert P. Harrison,*

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 19 1922*17 I HEREBY CERTIFY, That I attended deceased from *1/14/22* 19 to *1/19/22* 19that I last saw him alive on *1/14/22* 19and that death occurred, on the date stated above, at *130* P. M.

The CAUSE OF DEATH\* was as follows:

*Acute Bronchitis*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? *clinical*(Signed) *D. P. Harrison* M. D.1/20/22 (Address) *7919 E. Baltimore*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Manner and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

*John Herwig & Co*

DATE OF BURIAL

*Jan 23 1922*

ADDRESS

*2008 Alameda*

JAN 21 1922



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60498

## CERTIFICATE OF DEATH.

90 D 60498

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1913 Orleans St.; 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Schlemmer

(Residence in Baltimore: No. 1913 Orleans St. 35 yrs., mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE.

White

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

Married

## 6-DATE OF BIRTH.

Sept 25, 1858  
(Month) (Day) (Year)

## 7-AGE.

63 yrs. 3 mos. 22 ds.

If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

At home

## 9-BIRTHPLACE.

(State or Country).

Baltimore.

## 10-NAME OF FATHER.

Conrad Schaffer

## 11-BIRTHPLACE OF FATHER (State or Country).

Germany.

## 12-MAIDEN NAME OF MOTHER.

Dora Knorr

## 13-BIRTHPLACE OF MOTHER (State or Country).

Germany

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amelia Schlemmer

(Address) 1913 Orleans St.

## 15-

Robert P. Harrison

1912

Registrar.

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

Jan 19, 1912  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Sept 1, 1911, to Jan 19, 1912.

that I saw him alive on Jan 19, 1912.

and that death occurred, on the date stated above, at 4:50 a.m.

The CAUSE OF DEATH\* was as follows:

Weakness of the lungs  
(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Myocardial insufficiency

(Duration) yrs. mos. ds.

(Signed) J. S. Harrison M. D.

Jan 20, 1912 (Address) 1301 N. Kent St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

1st. Sur. Cr. Cemetery

## DATE OF BURIAL.

Jan 23 1912

## 20-UNDERTAKER

John Herwig &amp; Co

## ADDRESS

2008 Orleans

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

File

19

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

1-14

1922

to 1-19

1922

that I last saw him alive on 1-19 1922

and that death occurred, on the date stated above, at 7<sup>10</sup> m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of bladder

(duration) 1 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

Nephritis, Acidosis, Uræmia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Laboratory tests

(Signed) W. M. Zimring M. D.

Jan. 1922 (Address)

The Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Olivet Cem.

Jan 23 1922

20 UNDERTAKER

John Henry &amp; Co

ADDRESS

2008 Alameda

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AN 9-1-1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60500

## CERTIFICATE OF DEATH.

H5 D 60500

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *419 S. Ann St.*)ST.: *V* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Anastazyia Ciepirz*(Residence in Baltimore: No. *419 S. Ann St.*)St.: *32* yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *January 24*, 18*70*. (Month) (Day) (Year)7-AGE, *51* yrs., *11* mos., *26* ds. If LESS than 1 day, ....hrs. or ....min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Housewife* (b) General nature of industry, business, or establishment in which employed (or employer) *037*9-BIRTHPLACE, (State or Country), *Poland*10-NAME OF FATHER, *Harry Lewendowski*11-BIRTHPLACE OF FATHER (State or Country), *Poland*12-MAIDEN NAME OF MOTHER *Hedwig Raszka*13-BIRTHPLACE OF MOTHER (State or Country), *Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Michael Ciepirz*(Address) *419 S. Ann St.*

15-

Filed..... Robert P. Harrison,

Barrel Zernit Clerk Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *January 22*, 19*22*, 19*22*. (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *January*, 19*22*, to *Jan 20*, 19*22*, that I saw *him* alive on *Jan 19*, 19*22*, and that death occurred, on the date stated above, at *3:20 A.M.* The CAUSE OF DEATH\* was as follows:*Carcinoma of Prostate* (Duration)..... yrs. *7* mos. ....ds.

CONTRIBUTORY (Secondary) (Duration)..... yrs. ....mos. ....ds.

(Signed) *Arthur J. Boudin*, M. D. *Jan 22, 1922* (Address) *812 P. St. N. W.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ....mos. ....ds. In the State..... yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*St. Stanislaus Cem.* *Jan. 23, 1922*

20-UNDERTAKER, ADDRESS

*M. J. Sadowski*, *708 S. Ann St.*

CAUSE OF DEATH should be stated EXACTLY. PHYSICIAN should state very important. See instructions on back of certificate.

D 60501

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60501

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. P.H.S. HOSP. #56

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. FORT MCHENRY BALTIMORE MD. ST., 24 WARD)

2-FULL NAME JOSEPH MERSON,

(a) RESIDENCE NO. US. P.H.S. HOSP. # 56

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE 32 yrs. 8 Months 9 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tent. maker.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland.

10 NAME OF FATHER Jonathan Merson.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

unknown

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

unknown

14 Informant E.T. Rosenbrock (Registrar)

(Address)

US P HS Hosp #56 Baltimore Md

15 Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 18, 1922 to Jan 21, 1922.

that I last saw him alive on Jan. 21, 1922.

and that death occurred, on the date stated above, at 7:20 P.m.

The CAUSE OF DEATH<sup>2</sup> was as follows:

Tuberculosis chronic pulmonary far adv. &amp; active.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinic report/

(Signed)

H.D. Lust M. D.

1/21, 1922 (Address) US. PHS Hosp. # 56 Balto, Md

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

General Md.

UNDERTAKER

E.B. Harle

DATE OF BURIAL

1-21-22

ADDRESS

112 E West St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1922

Burial Permit Clerk.



THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19.—H. P. Co.—1000 Bks.

D 60502

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60502

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Banisack

(a) RESIDENCE. No. 2525 Fleet st.  
(Usual place of abode)

ST. 1 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

ds. How long in U. S., if of foreign birth Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE Years 51 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Leather tanner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Stanley Banisack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rosie Borowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hospital Records (Address) H. T. H.

15 Filed Robert F. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19, 19 22, to Jan. 20, 19 22.

that I last saw him alive on Jan. 20, 19 22.

and that death occurred, on the date stated above, at 8.20 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis L. Sadayhuizer M. D.

(Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Stanislaus Cem.

1-23 1922

20 UNDERTAKER

ADDRESS

John M. Weber

1803 Bank

D 60503

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60503

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 S Bethel ST.; V WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Infant Borowski

## (a) RESIDENCE. No.

706 S Bethel

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

14 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

white

## 5 Single, Married, Widowed, or Divorced (write the word)

single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Jan 6 1922

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.14

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

## 10 NAME OF FATHER

Witold Borowski

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

## 12 MAIDEN NAME OF MOTHER

Josephine ?

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

## 14

Informant (Address)

Witold Borowski  
706 S Bethel St

## 15

Filed

Robert P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan 20 1922

## 17

I HEREBY CERTIFY, That I attended deceased from  
Jan 6, 1922, to Jan 20, 1922,  
that I last saw him alive on Jan 20, 1922,  
and that death occurred, on the date stated above, at 9 30 in.  
The CAUSE OF DEATH\* was as follows:

Pericarditisover

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? clinical

(Signed)

W. J. Baylin

M. D.

1/21, 1922 (Address)

210. Ad. J. J.

\*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

H. HamiltonJan 21 1922John M. Stuber1803 Bank St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 21 1922

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No further history  
than infection of  
hand.*

D 60504

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60504

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph Hospital* ST. *9* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Eva Lauer*(a) RESIDENCE. NO. *3816 Fernwood Ave.* ST. *9* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *28* yrs. *9* mos. *11* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Married*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

*William Lauer*

6 DATE OF BIRTH (month, day, and year)

*April 9-1893*

7 AGE

*28*

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

*at home*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*

## PARENTS

10 NAME OF FATHER

*Louis Henderson*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balto. Md.*

12 MAIDEN NAME OF MOTHER

*Anna Kaptain*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balto. Md.*

14

Informant (Address)

*William Lauer 3816 Fernwood Ave.*

15

Filed

*Robert F. Harrison*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Jan 20 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 18 1922 to Jan 20 1922*that I last saw her alive on *Jan 20 1922*and that death occurred, on the date stated above, at *6:40 A.M.*

The CAUSE OF DEATH\* was as follows:

*Acute Nephritis*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Miscellaneous*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. W. Harvey* M. D., 19 (Address) *St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Oak Lawn Cem.**Jan 23 1922*

20 UNDERTAKER

ADDRESS

*Lally & Zieles**403 S. ...*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AN 9 1 1922



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60505

## CERTIFICATE OF DEATH.

57 D 60505

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3408 Fair ave

ST.: 76 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Louisa Kistner

(Residence in Baltimore: No. 3408 Fair ave

St.: 70 yrs., 1 mos., 8 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

widowed

## 6-DATE OF BIRTH,

December 12<sup>th</sup>, 1851  
(Month) (Day) (Year)

## 7-AGE,

70 yrs., 1 mos., 8 ds.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House

## 9-BIRTHPLACE, (State or Country),

Baltimore Md

## 10-NAME OF FATHER,

John Knapp

## 11-BIRTHPLACE OF FATHER (State or Country),

Germany

## 12-MAIDEN NAME OF MOTHER

Not known

## 13-BIRTHPLACE OF MOTHER (State or Country),

Germany

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marguerite Kistner

(Address) 3408 Fair ave

## 15-

Robert P. Harrison

Filed

191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

January 20<sup>th</sup>, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Dec 15, 1921, to Jan 20, 1922,

that I saw her alive on Jan 19, 1922,

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH\* was as follows:

Arteriosclerosis

(Duration) 7 yrs., 3 mos., 1 ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

1/20/22, 1922 (Address) 1013 S. E. Howard Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Mt Carmel Cem.

## DATE OF BURIAL,

Jan 22, 1922

## 20-UNDERTAKER

Eddy &amp; Co. Phila.

## ADDRESS

403 S. W. 1st St.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

JAN 21 1922

Burial Permit Clerk

THIS IS A PERMANENT RECORD. For item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Bks.

D 60506

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60506

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Harvard Hospital* ST., *7* WARD)

2-FULL NAME

*Baby Boy Wrenchel*

(a) RESIDENCE NO.

*4759 Park Heights Ave.* ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

2 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Unborn*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*1/17/22*

7 AGE

Years

Months

Days

*2*

If LESS than 1 day, 2 hrs. or 2 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Harvard Hospital*

10 NAME OF FATHER

*John Wrenchel*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balto. Md.*

12 MAIDEN NAME OF MOTHER

*Martha Hertel*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balto. Md.*

14

Informant (Address)

*John Wrenchel 4759 Park Heights Ave.*

15

Filed

*Robert F. Harrison,*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*1/20/1922*

17

I HEREBY CERTIFY, That I attended deceased from

*1/18/1922*, to *1/20/1922*,

that I last saw him alive on

*1/20/1922*

and that death occurred, on the date stated above, at

*11:20 p.m.*

The CAUSE OF DEATH\* was as follows:

*Cardiac stenosis due to trauma at delivery.*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *yes* Date of *1/17/22*

Was there an autopsy? *no*

*(low forceps)*

What test confirmed diagnosis?

(Signed)

*Julius Holofener*

M. D.

19

(Address)

*Harvard Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Arund Ridge Cemetery*

*1-21-22*

20 UNDERTAKER

ADDRESS

*Wm. T. Tuckner Sons*

*South Street*

N 81-1922

Burial Permit Clerk

D 60507

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60507

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 Franklin Terrace

ST.:

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gottfried Falkenberg

(a) RESIDENCE. No. 512 Franklin Terrace

ST.:

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 ~~Single~~ Married, Widowed,  
or Divorced (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or WIFE of)

Bolette Falkenberg

6 DATE OF BIRTH (month, day, and year) Nov 1st. 1848

7 AGE

Years

Months

Days

73

3

19

If LESS than  
1 day. hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Secretary &amp; Treas. (Retired)

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

Hotel Rennert Co.

9 BIRTHPLACE (city or town) Laurvig-Norway  
(State or country)

10 NAME OF FATHER Magnus Falkenberg

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Norway

12 MAIDEN NAME OF MOTHER Ottilia Soeberg

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Norway14 Informant August E. Falkenberg  
(Address) 512 Franklin Terrace

15 Robert F. Harrison,

Registrar

Barrel Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1922

17 I HEREBY CERTIFY, That I attended deceased from  
January 19, 1922, to Jan 20, 1922,  
that I last saw him alive on Jan 20, 1922,  
and that death occurred, on the date stated above, at 1:00 p. m.  
The CAUSE OF DEATH\* was as follows:Organic heart disease  
(Mitral Stenosis)  
(duration) yrs. 5 mos. 20 ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) H. M. Skene, M. D.

19 Address 10520 Lafayette

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Loudon Park Cemetery

Jan 23 1922

20 UNDERTAKER

ADDRESS

Bertram J. O'Connell 1723 7th Ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 21 1922

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AN 2

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60508

CERTIFICATE OF DEATH.

D 60508

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 220 3 Chestnut St. WARD 9)

2-FULL NAME

James C. Graham

(Residence in Baltimore: No. 220 3 Chestnut St.)

REGISTERED NO. C

(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

6-DATE OF BIRTH

June 3, 1859 (Month) (Day) (Year)

7-AGE

63 yrs. 7 mos. 17 ds.

If LESS than 1 day, ...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

Machinist

9-BIRTHPLACE, (State or Country),

New Jersey

10-NAME OF FATHER,

Not known

11-BIRTHPLACE OF FATHER (State or Country),

Not known

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER (State or Country),

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherine Graham

(Address) 156 Water St. Mt. Holly, N.J.

15-

Robert P. Harrison,

Filed 1922, 191. Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Jan 20, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

And that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Apoplexy (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) J. P. Harrison, D. (Coroner) 1-20-22 (Address) 156 Water St. Mt. Holly, N.J.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Mt. Holly, New Jersey

DATE OF BURIAL

Jan 24, 1922

20-UNDERTAKER

Girkler + Girkler

ADDRESS

1739 E. Eager



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60509

1-PLACE OF DEATH

REGISTERED NO. D 60509

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2205 McEldery

ST. 7 WARD)

2-FULL NAME

Edward Fowler

(a) RESIDENCE. NO. 2205 McEldery

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds. How long in U. S. If of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Cul

5 Single, Married, Widowed, or Divorced (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 18 - 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Wm Fowler

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Addie Sepney

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Addie Fowler 2205 McEldery

15

JAN 22 1922

ROBERT R. KRAUTER, Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 19 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 19 1922 to Jan 19 1922

that I last saw him alive on Jan 19 1922

and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH\* was as follows:

Infantile Convulsions  
in New Born due  
Retention of Urine

(duration) yrs. mos. ds.

CONTRIBUTORY Probable injury at birth

(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm J. P. Burns, M. D.

(Address) 2718 E Pratt

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laurel Cemetery Jan 22 1922

20 UNDERTAKER

ADDRESS

Milton Davis 317 E Edm.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 60510

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 60510

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

Staguen Hospital

St.

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Charles C. Beck

(Residence in Baltimore: No.

2802 Frederick Ave

St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Single

6-DATE OF BIRTH,

Jan

27

1891

7-AGE,

80 yrs. 11 mos. 21 da.

IF LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Shaffer  
Abatir

9-BIRTHPLACE, (State or Country),

Balt and

10-NAME OF FATHER,

Charles C. Beck

11-BIRTHPLACE OF FATHER (State or Country),

Pennsylvania

12-MAIDEN NAME OF MOTHER

Rhoda Perrey

13-BIRTHPLACE OF MOTHER (State or Country),

Balt. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Rhoda Johnson

(Address)

2802 Frederick Ave

15-

JAN 22 1922

ROBERT R. KRAUTER,

Bureau Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan

19

1922

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an

thereon and from the evidence obtained by said

The CAUSE OF DEATH was as follows:

Internal Hemorrhage  
from Stab Wound  
Heart & lungs Murder

CONTRIBUTORY (Secondary)

(Signed) James M. Denton  
22, 1922 (Address) 700 E. Chest

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Olivet Cem

DATE OF BURIAL,

23, 1922

20-UNDERTAKER

J. F. M. Conly

ADDRESS

130 E. Fort

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 60511

D 60511

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1131 E. Batio ST. 3 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 1131 E. Baltimore St. 35 yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*6-DATE OF BIRTH. *Unknown*, 1861. (Month) (Day) (Year)7-AGE. *60* yrs. mos. ds. If LESS than 1 day, ...hrs. or...min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Wholesale* 034 (b) General nature of industry, business, or establishment in which employed (or employer). *Grocer*9-BIRTHPLACE, (State or Country). *Russia*10-NAME OF FATHER. *Unknown*11-BIRTHPLACE OF FATHER (State or Country). *Russia*12-MAIDEN NAME OF MOTHER. *Unknown*13-BIRTHPLACE OF MOTHER (State or Country). *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. J. Schiffer*(Address) *1131 E. Baltimore St.*

15-

JAN 22 1922

ROBERT R. KRAUTER,  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 21<sup>st</sup>, 1922*. (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 15* 1921, to *Jan 18* 1922, that I saw him alive on *Jan 18* 1922, and that death occurred, on the date stated above, at *12<sup>20</sup>* a. m. The CAUSE OF DEATH\* was as follows:*Chronic interstitial nephritis and arterio sclerosis*  
(Duration) *2* yrs. mos. ds.CONTRIBUTORY (Secondary) *apoplexy*  
(Duration) *1* yr. mos. ds.(Signed) *Benj. V. Cadogan* M. D.*Jan 21, 1922* (Address) *2326 Eastland Pl.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. *Wheat Mt. Carmel* DATE OF BURIAL. *Jan 22, 1922*20-UNDERTAKER. *Jack Lewis 1411 E. Baltimore St.* ADDRESS

16-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60512

D 60512

## CERTIFICATE OF DEATH.

### 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 Spalding Avenue ST. 27 WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Nathan Friedman

(a) RESIDENCE NO. 124 Spalding Avenue ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Backus Friedman

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE Years 48 Months — Days — If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia (State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Jack Lewis (Address) 14 W 4th St

15 JAN 22 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21, 1922

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1921 to Jan 21, 1922 that I last saw him alive on Jan 20, 1922 and that death occurred, on the date stated above, at 10 am

The CAUSE OF DEATH\* was as follows:

Carcinoma of Colon  
Peritoneal Metastasis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 11, 1921

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) J. W. Hertzky M. D.

19 (Address) 2327 Cutaw Place

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL

Rehman Kessing Cum 1/22/22

20 UNDERTAKER ADDRESS

Jack Lewis 14 W 4th St



N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 60513 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 Pearl Street ST., 17 WARD)

2-FULL NAME

Alfred Weiskery

(a) RESIDENCE No.

522 Pearl Street ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 14 1909

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

11

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Hyman Weiskery

11 BIRTHPLACE OF FATHER (city or town) (State or country)

New York

12 MAIDEN NAME OF MOTHER

Rose Bars

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Jack Lewis 1411 E. Baltimore St.

15

Filed

JAN 22 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 21 1922

17

I HEREBY CERTIFY, That I attended deceased from January 17, 1922, to January 20, 1922, that I last saw him alive on January 20, 1922, and that death occurred, on the date stated above, at 1 A. M.

The CAUSE OF DEATH\* was as follows:

Chronic Inflammatory Rheumatism

CONTRIBUTORY (Secondary)

(duration) 3 yrs. mos. ds.

Endocarditis, Myocarditis, Pericarditis (duration) 8 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. S. K. M. D.

1/21/22 (Address) 1515 St. Pauline St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Washington 1/22/22

20 UNDERTAKER

ADDRESS

Jack Lewis 1411 E. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 60514 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2035 E 32<sup>nd</sup> ST., 9<sup>th</sup> WARD)

2-FULL NAME *Amalia Elizabeth Preide*

(a) RESIDENCE No. 2035 E 32<sup>nd</sup> ST., 9<sup>th</sup> WARD *North*  
(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred 29 yrs. 4 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Philip L. Preide*

6 DATE OF BIRTH (month, day, and year) *July 28, 1866*

7 AGE Years *55* Months *5* Days *24* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Washington D. C.*

10 NAME OF FATHER *John L. Hersinger*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*

12 MAIDEN NAME OF MOTHER *Anna D. Bester*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14 Informant *Theliff Preide*  
(Address) *2035 E 32<sup>nd</sup> St*

15 *JAN 22 1922* ROBERT R. KRAUTER,  
Bureau Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 21* 19 *22*.

17 I HEREBY CERTIFY, That I attended deceased from

*1918*, to *Jan. 21*, 19 *22*.

that I last saw her alive on *Jan. 14*, 19 *22*,

and that death occurred, on the date stated above, at *6<sup>15</sup>* a. m.

The CAUSE OF DEATH\* was as follows:

*valvular Heart disease*

(duration) *several* yrs. mos. ds.

CONTRIBUTORY (Secondary) *Base on disease*

(duration) *years* yrs. mos. ds.

18 Where was disease contracted if not at place of death? *no*

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Dr. Chas. T. Tietjen*, M. D.

, 19 (Address) *1702 Euclid Place*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Woodlawn Cem* *Jan 20 1922*

20 UNDERTAKER ADDRESS

*Louis's Heermann* *225 Broadway*

D 60515

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X 90

D 60515

## 1-PLACE OF DEATH

## REGISTERED NO.

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *13* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mr. Melford Saunders*(a) RESIDENCE. NO. *2530 Druid Hill Ave* ST. *17* WARD. *(Madison Dorchester, Md)*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *15* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*16 DATE OF DEATH (month, day, and year) *Jan 21, 1922*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mrs. Addie Saunders*17 I HEREBY CERTIFY, That I attended deceased from *Jan 7, 1922* to *Jan 21, 1922*that I last saw him alive on *Jan 21, 1922*and that death occurred, on the date stated above, at *1:35 p.m.*

The CAUSE OF DEATH\* was as follows:

*Cardiac decompensation*6 DATE OF BIRTH (month, day, and year) *Dec 17, 1862*7 AGE Years *59* Months *1* Days *4* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Sea Captain*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Md.* (State or country)10 NAME OF FATHER *John Saunders*11 BIRTHPLACE OF FATHER (city or town) *Md.*

(State or country)

12 MAIDEN NAME OF MOTHER *Patience*13 BIRTHPLACE OF MOTHER (city or town) *Md.*

(State or country)

14 Informant *Mercy Hospital Record* (Address)15 *JAN 22 1922* ROBERT R. KRAUTER, Registrar Burial Permit Clerk.CONTRIBUTORY (Secondary) *Pulmonary Tuberculosis* (duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Microscopic examination*(Signed) *John R. Brown* M. D., 19 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Shipment to Cambridge Md. Church Creek Jan 24<sup>th</sup> 1922*

20 UNDERTAKER ADDRESS

*George Schilling & Sons 1126 E. Monument St*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60516

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60516

CERTIFICATE OF DEATH

1-PLACE OF DEATH

Robert Garrett Hosp for children

REGISTERED NO.

CITY OF BALTIMORE: (No.

27 N Carey

ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William Bergoon

(a) RESIDENCE. NO.

714 N Carey

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

4

mos.

How long in U. S., if of foreign birth?

ys

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan. 30<sup>th</sup> 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

11

22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pennsylvania

10 NAME OF FATHER

William M. Bergoon

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Pennsylvania

12 MAIDEN NAME OF MOTHER

Mary O'Leary

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Pennsylvania

14

Informant Irving Thomas Read

(Address) 714 N. Carey St.

15

JAN 22 1922

ROBERT R. KRAUTER,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1922

17

I HEREBY CERTIFY, That I attended deceased from January 10, 1922, to January 21, 1922, that I last saw him alive on January 21, 1922, and that death occurred, on the date stated above, at 12<sup>45</sup> A. m.

The CAUSE OF DEATH\* was as follows:

Congestion & Edema of Lungs.

CONTRIBUTORY (Secondary)

(duration)

ys

mos.

ds.

few hours  
Convulsions & Intestinal Indigestion  
few hrs  
Life

(duration)

ys

mos.

ds.

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death? Circumcision Date of Jan 20 1922.

Was there an autopsy?

no

What test confirmed diagnosis? Physical Examination

(Signed)

1/21 1922 Address) 27 N Carey St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cem

June 23 1922

20 UNDERTAKER

Joseph B Cook

ADDRESS

103 N Balis St



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No.

1014 N. Stucker

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Unknown

ds. How long in U. S., if of foreign birth?

ys. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

black

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

12-1874(?)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

30

?

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ind

10 NAME OF FATHER

Edmund Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

15

Filed JAN 22 1922

ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1-19 1922

17

I HEREBY CERTIFY, That I attended deceased from

12-23, 1921, to 1-19, 1922

that I last saw him alive on 1-19, 1922

and that death occurred, on the date stated above, at 6:40 p. m.

The CAUSE OF DEATH\* was as follows:

Generalized Military Tuberculosis over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Spastic Paraplegia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 12, 22

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) R. R. Krauter, M. D.

, 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS 1303

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Operation for paraplegia  
Had Pott's disease, t.t.b. of  
intestines, lungs also  
involved.*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60518

## CERTIFICATE OF DEATH.

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Wd. Gen. Hosp.* ST. *M* WARD)

2-FULL NAME

*Frank W. Bowersock*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *4802 Delaware Ave.*

St. *64* yrs. *1* mos. *24* da.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*male*

4-COLOR OR RACE,

*white*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *widowed*

6-DATE OF BIRTH,

*Nov. 24, 1857*  
(Month) (Day) (Year)

7-AGE,

*64* yrs. *1* mos. *24* da.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*plumber*  
*059*

9-BIRTHPLACE, (State or Country).

*Baltimore Md.*

10-NAME OF FATHER,

*Geo. W. Bowersock*

11-BIRTHPLACE OF FATHER (State or Country).

*Baltimore Md.*

12-MAIDEN NAME OF MOTHER

*Elizabeth Spier*

13-BIRTHPLACE OF MOTHER (State or Country).

*Carroll Co. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Geo. W. Bowersock*

(Address)

*1843 Bellona Ave.*

15-

*JAN 22 1922*

ROBERT R. KRAUTER,

Burial Permit Clerk.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

*Jan. 19, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquiry* (Inquest, au-

*opsy or inquiry* find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Carbon monoxide poison (gas)*  
*accidental (gas hot water heater)*  
(Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... da.

(Signed) *J. E. Hennessy* M. D.  
(Coroner.)

*Jan. 21, 1922* (Address) *2872 Edmondson*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place *and* *his home* the of death ... yrs. ... mos. ... da. State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

*4802 Delaware Ave.*

Former or usual residence *same*

19-PLACE OF BURIAL OR REMOVAL,

*London Park*

DATE OF BURIAL,

*1-23*, 19*22*

20-UNDERTAKER

*Wm. Cook*

ADDRESS

*502 E. North Ave.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60519

60519

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Sq. 1403*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *721 E. Fort St.*)St.: *78* yrs., *9* mos., *29* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*male*

4-COLOR OR RACE.

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *widow*

6-DATE OF BIRTH.

*Mar 21, 1848*

(Month)

(Day)

(Year)

7-AGE.

*78 yrs., 9 mos., 29 ds.*

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*

9-BIRTHPLACE, (State or Country).

*Baltimore Md*

10-NAME OF FATHER.

*Vincent Shekels.*

11-BIRTHPLACE OF FATHER (State or Country).

*Md.*

12-MAIDEN NAME OF MOTHER

*Johnson*

13-BIRTHPLACE OF MOTHER (State or Country).

*Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-JAN 22 1922

Filed....., 191.....

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

*Jan - 20, 1922*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Jan 20 1922, to Jan 20 1922.*that I saw him alive on *Jan 20 1922*and that death occurred, on the date stated above, at *5:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Strangulated Hernia*CONTRIBUTORY (Secondary) *Unobstructed*(Signed) *H. C. Washburn* M. D.*Jan 20, 1922* (Address) *Franklin Sq. 1403*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *1* mo. *1* ds. In the State *1* yrs. *1* mo. *1* ds.Where was disease contracted, if not at place of death? *at Home*Former or usual residence *721 E. Fort St.*

19-PLACE OF BURIAL OR REMOVAL.

*Md. Olivet.*

DATE OF BURIAL.

*1-23, 1922.*

20-UNDERTAKER

*Wm Cook.*

ADDRESS

*502 E. North Ave.*



D 60520

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

84 D 60520

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Hebrew Hospital

ST. 27 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Eugene Hodgins

## (a) RESIDENCE NO.

Rogers &amp; Harrison

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Feb 26 - 1899

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

24

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Virginia

## 10 NAME OF FATHER

John R. Hodgins

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

## 12 MAIDEN NAME OF MOTHER

Mary Roberts

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

## 14

Informant (Address)

John R. Hodgins

ROBERT R. KRAUTER

JAN 22 1922

Burial Permit Clerk

## 20 UNDERTAKER

William Cook

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL  
Hoodlawn Center

## DATE OF BURIAL

1/24/22

## ADDRESS

502 East

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 21 1922

17

I HEREBY CERTIFY, That I attended deceased from December 22, 1921, to January 21, 1922, that I last saw him alive on January 21, 1922,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH\* was as follows:

Medullary Edema

(duration) yrs. mos. 1/2 hr.

CONTRIBUTORY (Secondary)

Brain Tumor (Medulla Oblongata)

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of January 20, 1922

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) James J. Smith M. D.

191, 1922 Address The Hebrew Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL  
Hoodlawn Center

## DATE OF BURIAL

1/24/22

## ADDRESS

502 East

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60521

## CERTIFICATE OF DEATH.

D 60521

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *307 N. Arlington* ST.: *18* WARD)2-FULL NAME *Nancy Davis Cramblitt*(a) RESIDENCE. NO. *307 N. Arlington* ST.: *18* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *60* yrs. *0* mos. *0* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Widow*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of *George H Cramblitt*6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE

Years *82*Months *—*Days *—*If LESS than 1 day, hrs. or min. *—*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Nurse*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Penna. U.S.*10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Unknown*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*

14

Informant (Address) *Mr. May Thompson*  
*307 N. Arlington Ave.*

15

JAN 22 1922

ROBERT J. RAUTER, Registrar  
Burial Permit *118*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 21* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *June* 19*20* to *Jan 21* 19*22*.that I last saw him alive on *Jan 21* 19*22*.and that death occurred, on the date stated above, at *3 a. m.*

The CAUSE OF DEATH\* was as follows:

*Interstitial Nephritis -  
Dilatation of Heart*(duration) yrs. *6* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *no* Date of *no*Was there an autopsy? *no*What test confirmed diagnosis? *Urinary*(Signed) *M. G. Smith* M. D.1-21, 1922 (Address) *118 N. Calhoun*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mount Olivet Cemetery* *Jan 23* 19*22*20 UNDERTAKER *Charles F. Walker*

ADDRESS

*723 N. Lafayette Ave*

N. B.—WRITE PLAINLY, WITH EXACTNESS. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60522

## CERTIFICATE OF DEATH.

31 D 60522

## 1. PLACE OF DEATH

CITY OF BALTIMORE (No. 3964 Falls Road ST. 13 WARD)

## 2. FULL NAME

Harry M. Monaker

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

13964 Falls Road ST. 13 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Anne Blanche Monaker

6 DATE OF BIRTH (month, day, and year)

Oct. 27-1883

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

38

2

23

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Fire Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

066

(c) Name of employer

9 BIRTHPLACE (city or town, State or country)

Carroll Co. Maryland

10 NAME OF FATHER

John G. Monaker

11 BIRTHPLACE OF FATHER (city or town, State or country)

Carroll Co. Maryland

12 MAIDEN NAME OF MOTHER

Mary E. Tyson

13 BIRTHPLACE OF MOTHER (city or town, State or country)

Carroll Co. Maryland

14

Informant (Address)

Mrs. Annie Blanche Monaker 3964 Falls Road

15

JAN 22 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan. 19 1922

17

I HEREBY CERTIFY, That I attended deceased from

June 19 21, to Jan. 19 1922.

that I last saw him alive on Jan. 19, 1922.

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH\* was as follows:

Acute Pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Pulmonary Tuberculosis

(duration) 2 ? yrs. mos. ds.

18 Where was disease contracted

if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. H. Machin, M. D.

19 (Address) 4119 Falls Road

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR RE-

DATE OF BURIAL

St. Mary's (Hampton)

Jan. 23 1922

20 UNDERTAKER

ADDRESS

Horace H. Burgee 363 Falls Rd.

N. B.—WRITE PLAINLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

D 60523

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60523

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3610 Roland Ave ST., 13 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Anna Mary Caltrider

## (a) RESIDENCE NO.

3610 Roland Ave ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

39 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

F

## 4 COLOR OR RACE

W

## 5 Single, Married, Widowed, or Divorced (write the word)

W

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Jack Caltrider

## 6 DATE OF BIRTH (month, day, and year)

Feb 3/1886

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

85222

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

000

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Carroll Co

## 10 NAME OF FATHER

Geo. Sellers

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Belinda Brooks

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Carroll Co. Md.

## 14

Informant (Address)

Alvin H. Caltrider  
3610 Roland Ave

## 15

Filed

19

JAN 22 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan 22 1922

## 17

I HEREBY CERTIFY, That I attended deceased from Nov 15, 1921, to Jan 22, 1922.that I last saw her alive on Jan 21, 1922, and that death occurred, on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Edema

## CONTRIBUTORY (Secondary)

Interstitial Nephritis

## 18 Where was disease contracted if not at place of death?

HomeDid an operation precede death? No Date of -Was there an autopsy? NoWhat test confirmed diagnosis? Urinary Exam  
(Signed) Harry C. Alger, M. D.Address 3640 Roland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Almond RidgeJan 24 1922

## 20 UNDERTAKER

## ADDRESS

Horace H. Burque 3631 Falls Rd.

N. B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.







## HEALTH DEPARTMENT—CITY OF BALTIMORE

B 60526

## CERTIFICATE OF DEATH.

D 60526

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

804 N. Payson

ST.;

WARD)

REGISTERED NO. C

## 2-FULL NAME

Elenora Kerr

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

804 N. Payson

St. No. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OF RACE.

White

## 5-STATUS

MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

Married

## 6-DATE OF BIRTH.

Jan 9, 1847

## 7-AGE.

75 yrs. 13 mos. ds.

## If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

at home

9-BIRTHPLACE,  
(State or Country).

Baltimore Md

## 10-NAME OF FATHER.

Peter Steko

11-BIRTHPLACE OF FATHER  
(State or Country).

Kent Co

## 12-MAIDEN NAME OF MOTHER

Marian

13-BIRTHPLACE OF MOTHER  
(State or Country).

Kent Co

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Marian E. Sewell

(Address)

1100 N. Wolfe St.

## 15-

JAN 23 1922

Filed

ROBERT R. KRAUTER,

191

Burial Permit

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

Jan 22, 1922

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Jan 19 1922, to Jan 22 1922

that I saw her alive on Jan 21 1922

and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH\* was as follows:

Senility and  
acute bronchitis

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Jan 22, 1922 (Address) 1100 N. Wolfe St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

## DATE OF BURIAL.

Rock Hall Md Jan 23 1922

## 20-UNDERTAKER

## ADDRESS

William Hall 502 E. Pratt

N.B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.





## HEALTH DEPARTMENT—CITY OF BALTIMORE

H. 9 (64) 0528

D 60528

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2914 Overland St., 27 WARD)

## 2. FULL NAME

John Andrew Wagner

## (a) RESIDENCE NO.

2914 Overland St.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced, HUSBAND OF (or) WIFE OF

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14

Informant

(Address)

15

JAN 23, 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-22-1922

17

I HEREBY CERTIFY That I attended deceased from Oct 5, 1921, to Jan 22, 1922.

that I last saw him alive on Jan 21, 1922.

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia of Peritone

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

, 19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-OVAL

Parkwood

20 UNDERTAKER

William Cook

DATE OF BURIAL

1/25, 1922

ADDRESS

502 E North

Jm

N. B.—WRITE FULL NAME, AGE, SEX, and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60529

D 60529

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1052 N. Melton Ave* ST.: *7* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Melham Charles Rider*(a) RESIDENCE. No. *1052 N. Melton Ave* ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *4 5* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Margaret Rider*6 DATE OF BIRTH (month, day, year) *December 21/1863*7 AGE Years *58* Months *0* Days *20* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Carpenter*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Bethesda Md.*  
(State or country)10 NAME OF FATHER *August Rider*11 BIRTHPLACE OF FATHER (city or town) *Germany*  
(State or country)12 MAIDEN NAME OF MOTHER *Dorothy Bloomer*13 BIRTHPLACE OF MOTHER (city or town) *Germany*  
(State or country)

14

Informant *Margaret A. Rider*  
(Address) *1052 N. Melton Ave*

15

File *JAN 23 1922*

ROBERT R. KRAUTER,

Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, year) *January 20 1922*17 I HEREBY CERTIFY, That I attended deceased from *June 15 1921* to *Jan 20 1922*that I last saw him alive on *Jan 20 1922*and that death occurred, on the date stated above, at *11 P.* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Coronary Arteriosclerosis  
Myocarditis*(duration) yrs. *6* mos. ds.

CONTRIBUTORY (Secondary) ? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *No*Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Physical Exam*(Signed) *Geoffrey M. O'Neil*, M. D.Address *401 E 25th St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*St. John's Lutheran Church*

20 UNDERTAKER

*William Cook*

DATE OF BURIAL

*1/24 1922*

ADDRESS

*502 E North**JR*

Information should be carefully supplied. AGE should be stated in years, months, and days. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60530

## CERTIFICATE OF DEATH.

REGISTERED NO. 174 D. 60530

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2606 Francis ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Hunter

(a) RESIDENCE. NO. 2606 Francis ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 0 ds. How long in U. S., if of foreign birth? yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Hunter

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE Years 73 Months 0 Days 0 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Wm. Hopper

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Oakley

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Geo W. Hunter (Address) 1605 N. Belvoir

15 JAN 23 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 9, 1921, to Jan 21, 1922, that I last saw her alive on Jan 21, 1922, and that death occurred, on the date stated above, at 2.10 A.M. The CAUSE OF DEATH\* was as follows:

Chronic nephritis  
Interstitial  
(duration) yrs. mos. ds.

CONTRIBUTORY cause (Secondary) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? (Signed) Dr. Theo. K. Schneider, M.D.

(Address) 22-22 3450 Fulton

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

Baltimore 1/24 1922  
William Cook 502 E. North

Information should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60531

## CERTIFICATE OF DEATH.

REGISTERED NO.

D 60531

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *175 S. Castle* ST., *V* WARD)

## 2. FULL NAME

(a) RESIDENCE NO. *175 S. Castle* ST., *V* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *70* yrs. mos. ds. How long in U. S., if of foreign birth? *70* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*5a If married, widowed, or divorced HUSBAND of *Jacob Schell* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *March 15-1830*7 AGE Years *91* Months *10* Days *5* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Germany* (State or country)10 NAME OF FATHER *Martin Schell*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)14 Informant *Theresa Schell (Daughter)* (Address) *175 S. Castle St.*15 *JAN 23 1922* ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan. 20 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan 1 1922* to *Jan 20 1922*, that I last saw him alive on *Jan 20 1922*, and that death occurred, on the date stated above, at *4:45 P. M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Bronchitis*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Geo. J. Gorman* M.D. (Address) *1102 Springton Rd.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Holy Redeemer Ch. Jan. 20 1922*  
*Lilly E. Fisher* *403 S. 21st St.*

N.B.—WRITE FULL NAME, AGE, SEX, and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.



D 60532

HEALTH DEPARTMENT—CITY OF BALTIMORE 081 60532

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Sarah Lucive Roman

(a) RESIDENCE. No.

1579 David Hill Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

5-23-1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7 29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Louis C. Roman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

D. Letta Dodd

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

15

JAN 23 1922

ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-21 1922

17

I HEREBY CERTIFY, That I attended deceased from

12-13 1921, to 1-21 1922.

that I last saw him alive on 1-21 1922.

and that death occurred, on the date stated above, at 12-21 a m.

The CAUSE OF DEATH\* was as follows:

Hydrocephalus

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death?

Yes Date of Dec. 10 '21

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

L. H. Holman, M. D.

1-21 1922 Address

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

M. Auburn  
Wm. H. Chase & Son 1400 Mosher St

D 60533 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

701 D 60533

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. CHURCH HOME &amp; INFIRMARY ST., 27 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME MARY LOUISE BOTTOMORE

(a) RESIDENCE No. 6210 York Road, ST., 27 WARD (Resident)  
(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred 84 yrs. 9 mos. 8 ds. How long in U. S., if of foreign birth? 84 yrs. 9 mos. 8 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Uriah John Bottomore

6 DATE OF BIRTH (month, day, and year) April-12-1837

7 AGE Years Months Days If LESS than 1 day, hrs or min.  
84 9 8

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer) None  
(c) Name of employer None9 BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland

10 NAME OF FATHER Geo. Lewis Trogler

11 BIRTHPLACE OF FATHER (city or town) Wittenburg  
(State or country) Germany

12 MAIDEN NAME OF MOTHER Esther Boston

13 BIRTHPLACE OF MOTHER (city or town) Somerset Co.  
(State or country) Maryland14 Informant Sarah Louise Bottomore (daughter)  
(Address) 6210 York Road-City.15 JAN 23 1922 ROBERT R. KRAUTER,  
Burial Permit

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/20 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1922, to Jan 20, 1922, that I last saw her alive on Jan 20, 1922, and that death occurred, on the date stated above, at 4:45 p.m.  
The CAUSE OF DEATH\* was as follows:  
Intra Capsular Fracture of Right FemurCONTRIBUTORY (Secondary) Lobar Pneumonia  
(duration) yrs. 1 mos 22 ds.  
(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? 6210 York Road

Did an operation precede death? No. Date of  
Was there an autopsy?What test confirmed diagnosis?  
(Signed) W. D. Noble, M. D.  
, 19 (Address) Church Home Inf.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL  
Govans Presbyterian Cem. Jan-23-2220 UNDERTAKER ADDRESS  
STEWART & MOWEN COMPANY 103 W. NORTH AVE.  
(WILLIAM F. WOODEN, Successor)

N. B.—WRITER'S ATTENTION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation should be given. See instructions on back of certificates.

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name organ; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Traumatic  
Pathological fracture  
cause unknown*

THE CHURCH HOME AND INFIRMARY  
OF THE  
CITY OF BALTIMORE

January 25, 1922

Dr. C. Hampson Jones  
Health Department,  
Baltimore, Md.

My dear Dr. Jones:

In reference to Mrs.  
Mary Bottomore's diagnosis please change  
the primary cause of death from Intra-  
Trochanteric fracture of rt. femur (path-  
ological) to - to Intra-Trochanteric frac-  
ture of right femur, traumatic.

Very truly yours,

*Wm. D. Noble*  
Wm. D. Noble  
Resident.

N-D





## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60534

## CERTIFICATE OF DEATH.

90 D 60534

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #127-West-Lanvale-St. ST. 11 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME PIERRE OTIS KEILHOLTZ.

(a) RESIDENCE No. #127-West-Lanvale-St ST. 11 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred 59 yrs 8 mos 30 ds. How long in U. S., if of foreign birth? 59 yrs 8 mos 30 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)  
MALE WHITE MARRIED5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Helen Cecelia Keilholtz

6 DATE OF BIRTH (month, day, and year) April-22-1862

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
59 8 30

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Consulting Engineer. 030

(b) General nature of industry, business, or establishment in which employed (or employer) Engineering.

(c) Name of employer (self)

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland

10 NAME OF FATHER Otis Keilholtz

11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emily Shennessey

13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country) Maryland14 Informant Mrs. Helen C. Keilholtz (wife)  
(Address) 127-W-Lanvale-St., City.15 JAN 23 1922 ROBERT A. KRAUTER,  
Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 17 1922, to Jan 21 1922, that I last saw him alive on Jan 21 1922, and that death occurred, on the date stated above, at 3:00 P. M.

The CAUSE OF DEATH\* was as follows:

Acute Cordiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) St. Andrew M. C. M. D.

19 (Address) 1609 Linden Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

GREEN MOUNT CEMETERY

Jan-24-22

20 UNDERTAKER STEWART & MOWEN COMPANY  
(WILLIAM F. WOODEN, Successor)

ADDRESS

103 W. NORTH AV

Information should be carefully supplied, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 60535

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1611 E Eager* ST. *7* WARD)2-FULL NAME *Henry G. Mueller*(a) RESIDENCE NO. *1611 E Eager*

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred *66* yrs. *11* mos. *24* ds.How long in U. S., if of foreign birth? *66* yrs. *11* mos. *24* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Widowed*

5a If married, widowed, or divorced

HUSBAND of *Ella Mueller*

(or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Jan 27 1855*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*66**11**24*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Tailor*

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto*

(State or country)

10 NAME OF FATHER *Joseph Mueller*11 BIRTHPLACE OF FATHER (city or town) *Kennedy*

(State or country)

12 MAIDEN NAME OF MOTHER *Not known*13 BIRTHPLACE OF MOTHER (city or town) *Not known*

(State or country)

14

Informant *Mr. Joseph Mueller*(Address) *1611 E Eager*

15

JAN 23 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 21 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan. 12, 1922* to *Jan. 21, 1922*that I last saw him alive on *Jan. 21, 1922*and that death occurred, on the date stated above, at *7:40 P.M.*

The CAUSE OF DEATH\* was as follows:

*Cardiac dilatation of**chronic bronchitis*(duration) *not definite* mos. ds.CONTRIBUTORY *Scrub typhus*

(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *no*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis *Erythema*(Signed) *Benjamin H. Hayden* M. D.*1/22, 1922* (Address) *1216 N. Caroline St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL *Holy Redeemer Cemetery*DATE OF BURIAL *Jan 24, 1922*20 UNDERTAKER *Henry Sobell, Son*ADDRESS *1611 E Eager*

D 60536

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *N. Broadway* ST. *6* WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *2* mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

JAN 23 1922

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

No. *32*, 19*22*, to *Jan 22*, 19*22*that I last saw him alive on *Jan 22*, 19*22*and that death occurred, on the date stated above, at *10:15 a.m.*

The CAUSE OF DEATH\* was as follows:

*(Cardiac failure) over Myocardial Insufficiency*(duration) yrs. *1* mos. ds.CONTRIBUTORY *Euphyema, Mitral Stenosis +*(Secondary) *Valvular Disease of Aorta* (duration) yrs. *6* mos. ds.18 Where was disease contracted if not at place of death? *Savannah, Ga.*Did an operation precede death? *Yes* Date of *Dec 7, 1922*Was there an autopsy? *No*What test confirmed diagnosis? *X-ray + operation*(Signed) *Richard P. Bohrer*, M. D.19 (Address) *Church Home, 407 1st St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

1-23-22 1922

ADDRESS *300 E. Baltimore*

20 UNDERTAKER

*John A. Moran*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60537

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3020 Arunah Ave. ST. 16 WARD)

2-FULL NAME Mary, Ann Stump

(a) RESIDENCE. No. 3020 Arunah Ave. ST. WARD. (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of Henry J. Stump (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24th, 1853

7 AGE Years 68 Months 5 Days 28 If LESS than 1 day. hrs. or min.

8 OCCUPATION OF DECEASED Housework

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

10 NAME OF FATHER John Dodd

11 BIRTHPLACE OF FATHER (city or town) England (State or country)

12 MAIDEN NAME OF MOTHER Jane McAlister

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Henry J. Stump (Address) 3020 Arunah Ave

15 JAN 23 1922

ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1922

17 I HEREBY CERTIFY, that I attended deceased from Dec 6, 1921, Jan 22, 1922, that I last saw him alive on Jan 21, 1922, and that death occurred, on the date stated above, at 1:30 a.m. The CAUSE OF DEATH\* was as follows: Pulmonary Tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam of Sputum

(Signed) John A. Giddens, M. D.

19 (Address) 101 N. Carey.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Druid Ridge Cemetery

DATE OF BURIAL

Jan. 24th 22

20 UNDERTAKER

Vertram B. Fore

ADDRESS

1723 N. Lafayette Ave



N. B.-Every item of information should be carefully supplied. AGE should be stated exactly. Exact statement of OCCUPATION should be stated exactly. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. is very important.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 60538

CERTIFICATE OF DEATH

REGISTERED NO. C

D 60538  
PLACE OF DEATH

CITY OF BALTIMORE (No. 16)

2-FULL NAME

(Residence in Baltimore: No. 701 N. Carey St)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and full out No. 18.)

Str.: yrs. 1 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

JAN 23 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17-I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Contributory (SECONDARY)

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds.  
Where was disease contracted.  
If not at place of death?  
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

20-UNDERTAKER

DATE OF BURIAL

1-23-1922

ADDRESS

D 60539 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60539

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Pons(a) RESIDENCE. No. 1212 W. Lexington st. ST.      WARD.       
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred Unknown yrs.      mos.      ds. How long in U. S., if of foreign birth? yrs.      mos.      ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Separated5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18577 AGE Years 64 Months      Days      If LESS than 1 day, hrs.      or min.     

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER John Pons11 BIRTHPLACE OF FATHER (city or town) (State or country) Spain12 MAIDEN NAME OF MOTHER Olevia Wheeler13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant Hospital Records(Address) M.T.H.15 Filed JAN 23 1922

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21, 192217 I HEREBY CERTIFY. That I attended deceased from December 19, 1921, to Jan. 21, 1922.that I last saw him alive on Jan. 20, 1922.and that death occurred, on the date stated above, at 6.10 a. m.

The CAUSE OF DEATH\* was as follows:

pulmonary tuberculosis(duration) 2 yrs.      mos.      ds.CONTRIBUTORY Senile Dementia  
(Secondary) (duration)      yrs.      mos.      ds.18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? NO Date of     Was there an autopsy?     What test confirmed diagnosis? T.B. in sputum X-ray  
(Signed) James L. Dugan M. D.1-21-22 (Address) Municipal Tbc. Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral Ave Jan 24 1922

20 UNDERTAKER

Roberto Brookeson HOLLINGS

D 60540 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60540

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 St Paul ST., 11 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

ST., WARD

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Sache M. Warner

6 DATE OF BIRTH (month, day, and year)

Apr. 5 1881

7 AGE

Years 40

Months 9

Days 15

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

Drugs Wholesale

(c) Name of employer

Carroll &amp; Co.

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Wm P. Warner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Anna McGowan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Wm P. Warner 2746 Chester St.

15

Filed

JAN 23 1922

ROBERT R. KRAUTER,

Bureau Permit Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 23, 1921, to Jan 20, 1922,

that I last saw him alive on Jan 20, 1922,

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Leivic viscera

(duration) about 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of Dec 13/21

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. E. Knapp, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Lorraine Cemetery

20 UNDERTAKER

Robert Brookeson

DATE OF BURIAL

JAN 22 1922

ADDRESS COR

CALHOUN

HOLLINS

STS

Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60541

## CERTIFICATE OF DEATH.

REGISTERED NO.

D 60541

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 O. Lakewood Ave., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olava Andersen

(a) RESIDENCE NO. 518 O. Lakewood Ave., ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Christian Andersen

6 DATE OF BIRTH (month, day, and year) April 26, 1854

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

67 8 24

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Norway

10 NAME OF FATHER Ole Olsen

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Norway

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Norway

14 Informant Christian Anderson  
(Address) 518 O. Lakewood Ave.

15 JAN 23 1922 ROBERT R. KRAUTH, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 20, 1922

I HEREBY CERTIFY, that I attended deceased from

Jan 15, 21, Jan 20, 22

that I last saw her alive on Jan 20, 1922

and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH\* was as follows:

Senility

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

Chorea, Insults Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Chorea

(Signed) J. H. Insley, M. D.

1-21-22 (Address) 2238 E. Baltimore

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

London Park Jan 24, 22

20 UNDERTAKER

H. Sander Sons 1710 E. North St.



D 60542

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60542

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2035 M. C. Puller, ST. 14 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. 2035 M. C. Puller, ST.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 3, 1891

7 AGE Years 30 Months 3 Days 16 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Eastern Shore (State or country) Md

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

## 14

Informant (Address)

## 15

File

JAN 23 1922

ROBERT R. KRAUSE

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21, 1922

17 I HEREBY CERTIFY that I attended deceased from Dec 23rd, 1921, to Jan 21st, 1922,

that I last saw her alive on Jan 21st, 1922,

and that death occurred, on the date stated above, at 6:35 A. M.

The CAUSE OF DEATH\* was as follows:

Acute Pharyngitis &amp; Myocardial Insufficiency (duration) 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Rheumatism (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Physical (Signed) Geo. H. Lattenbach, M. D.

(Address) 225 N. Route Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.  
[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Cause of cholecystitis  
unknown to phy.  
Only cause he could  
give was a run down  
condition & debility*

D 60543 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60543

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5230 Green ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. 5230 Green ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Fm.

4 COLOR OR RACE

Col.

5 Single, Married, Widowed,

or Divorced (write the word)

widow

6a If married, widowed, or divorced

HUSBAND of

OR WIFE of

Thos. Scott

6 DATE OF BIRTH (month, day, and year)

-- 1847

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

64

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

General

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md

10 NAME OF FATHER

Aylmer O'Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Mary Elder

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant

(Address)

Albert Scott

520 Wheel St

15

Fm.

JAN 23 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1/21/22

17

I HEREBY CERTIFY, That attended deceased from

11/4/21, 1921, to 1/20/22, 1922,

that I last saw him alive on

1/20/22, 1922,

and that death occurred, on the date stated above, at

34. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY

(Secondary)

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1/21/22 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

St. John's Lane Jan 23 1922  
Burial Permit Clerk

D 60544

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60544

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2007 Jefferson ST., 6 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

40 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

## 5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

late Barbara Simon

## 6 DATE OF BIRTH (month, day, and year)

Feb 10/68

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

53

11

11

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Himself

## 9 BIRTHPLACE (city or town) (State or country)

Germany

## 10 NAME OF FATHER

Henry Simon

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Theresa

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

## 14

Informant  
(Address)Henry Simon  
9007 Jefferson

JAN 23 1922

ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan 21 1922

## 17 I HEREBY CERTIFY, That I attended deceased from

Nov 2 1921 to Jan 21, 1922.

that I last saw him live on Jan 20, 1922.

and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH\* was as follows:

Chr. Bronchitis

## CONTRIBUTORY (Secondary)

(duration)

yrs.

da.

(duration)

yrs.

mos.

da.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

G. G. F. M. D.

(Address) 14376 3rd Ave

\*State Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

ADDRESS

M. Carmel  
Philip Hennig  
2016 Adams



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Not tuberculous.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60545

D 60545

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 Glenmore Ave. 27 WARD)

## 2. FULL NAME

(a) RESIDENCE NO. 103 Glenmore Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,

or Divorced, (write the word)

5a If married, widowed, or divorced

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

JAN 23 1922

ROBERT R. KRAUTER,

Serial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
July 7, 1921 to Jan 22, 1922.

that I last saw him alive on Jan 20, 1922.

and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH\* was as follows:

Angina Pectoris

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1/22, 1922

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1-13-1866

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

56

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

JAN 23 1922

ROBERT S. KRAUTER, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1-23 1922

17

I HEREBY CERTIFY, That I attended deceased from

12-2 1921, to 1-23 1922

that I last saw him alive on 1-23 1922

and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic myeloid Leukemia

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. B. Hannan, M. D.

19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Greenmount Ceme. H. W. Jenkins &amp; Sons Co.

1-24 1922

W. Cullum Orchard





## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60548

## CERTIFICATE OF DEATH.

REGISTERED NO.

D 60548

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 East Ave ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. 10 mos.

ds.

How long in U. S., if of foreign birth? Life mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5-Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

32 Years

Months

10

Days

14

If LESS than  
1 day, hrs  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

JAN 23 1922

ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
Jan 4, 1922, to Jan 21, 1922.  
that I last saw him alive on Jan 20, 1922,  
and that death occurred, on the date stated above, at 9:50 a.m.

The CAUSE OF DEATH\* was as follows:

Perishable ArteriesCONTRIBUTORY  
(Secondary)18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60549

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1809 Wilhelm St. ST., 19 WARD)

2. FULL NAME Margie E. Blankner

(a) RESIDENCE NO. 1809 Wilhelm St. ST., WARD (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 27<sup>th</sup> 1921

7 AGE Years 9 Months 26 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER George M. Blankner

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary R. Crofoot

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant George M. Blankner (Address) 1809 Wilhelm St.

15 ROBERT R. KRAUTER, Registrar JAN 23 1922 Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22<sup>nd</sup> 19 22

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1922, to Jan 22, 1922, that I last saw him alive on Jan 22, 1922, and that death occurred, on the date stated above, at 10.30 P.m. The CAUSE OF DEATH\* was as follows:

Pulmonary edema

CONTRIBUTORY (Secondary) (duration) yrs. mos. 1 ds. Bronchopneumonia (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jan. 23<sup>rd</sup> 1922 Address 1729 N. Bond St. M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

London Park Cem Jan 24, 1922 ADDRESS

20 UNDERTAKER Joseph B. Cook 603 N. Baltimore St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60550

D 60550

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

Morrow Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1122 N. Mount

ST., 21

WARD)

2-FULL NAME

Warren Heuer

(a) RESIDENCE NO.

1123 N. Hamburg

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. 7 mos. 6 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 14 1883

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

38 7 6

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Frederick W. Heuer

11 BIRTHPLACE OF FATHER (city or town)

Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER

Johanna Roenick

13 BIRTHPLACE OF MOTHER (city or town)

Germany

(State or country)

14

Informant

(Address)

Mrs Wagner

1123 N. Hamburg

15

JAN 23 1922

ROBERT R. KRAUTER

Burial Permit Clerk

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mount Carmel

20 UNDERTAKER

Henry Lutz

DATE OF BURIAL

Jan 24 1922

ADDRESS 1203

N. Broadway

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-20-1922

17 I HEREBY CERTIFY, That I attended deceased from

1-12-1922 to 1-20-1922

that I last saw him alive on 1-20-1922

and that death occurred, on the date stated above, at 10:45 p.m.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia.

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard R. Tolson, M.D.

, 19 (Address) 1122 N. Mount

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

D 60551 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST. 76 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth

Life yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced. (write the word)

Male

White

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant  
(Address)

15

JAN 23 1922

ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 21, 1922, to Jan 22, 1922,

that I last saw him alive on Jan 22, 1922,

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia  
(Right Base)CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. 6 ds.

Cardiac Failure

(duration) yrs. mos. 9 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Moses Paulson, M. D.

19 (Address) Hebrew Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Hebrew Washington Road

1-22 1922

Jack Lewis

1411 E. Baltimore



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60552

## CERTIFICATE OF DEATH.

179 D 60552

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3422 Roland Ave. ST. 13 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Amos N. Ruby*

(a) RESIDENCE. NO. 3422 Roland Ave. ST. 13 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

30

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) *Sally Ruby*6 DATE OF BIRTH (month, day, and year) *Unknown*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *73*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Carroll Co. Md.* (State or country)10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) *Unknown* (State or country)12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) *Unknown* (State or country)14 Informant *Sally Ruby* (Address) *Roland Ave*

15 JAN 23 1922 ROBERT R. KRAUTER, Burlat Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *1-20* 19 *22*17 I HEREBY CERTIFY That I attended deceased from *July 1*, 19 *21*, to *Jan 20*, 19 *22*, that I last saw him alive on *Jan 19*, 19 *22*, and that death occurred, on the date stated above, at *8:15* m.

The CAUSE OF DEATH\* was as follows:

*Cerebral Insult  
ref. writer*(duration) yrs. *6* mos. *2* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. *2* mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical exam*(Signed) *C. F. Conroy* M. D.120, 19 *22* (Address) *3701 Roland Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*St. Marys Hospital Jan 23 19 22*

20 UNDERTAKER

ADDRESS

*Chenoweth Son Chestnut*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60553

## CERTIFICATE OF DEATH.

90 D 60553

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3514 Hickory Ave* ST. *13* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *John E. Weckesser*(a) RESIDENCE. NO. *3514 Hickory Ave* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *24* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *✓*6 DATE OF BIRTH (month, day, and year) *Aug 12 1897*7 AGE Years *24* Months *5* Days *8* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Chauffer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Ind* (State or country)10 NAME OF FATHER *Harry E. Weckesser*11 BIRTHPLACE OF FATHER (city or town) *Ind* (State or country)12 MAIDEN NAME OF MOTHER *Mary Keller*13 BIRTHPLACE OF MOTHER (city or town) *Ind* (State or country)14 Informant *Harry E. Weckesser* (Address) *3514 Hickory Ave*15 Filed *JAN 23 1922* 19

ROBERT K. HAZUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 20 1922*17 I HEREBY CERTIFY, That I attended deceased from *Oct 1 - 1921* to *Jan 20 1922*that I last saw him alive on *Jan 20 1922*and that death occurred, on the date stated above, at *530 P* m.

The CAUSE OF DEATH\* was as follows:

*Acute Insufficiency*(duration) yrs. *3* mos. ds.CONTRIBUTORY *Cardiac Dilatation* (Secondary) (duration) yrs. *2* mos. ds.18 Where was disease contracted *Ind* If not at place of death?Did an operation precede death? *Ind* Date ofWas there an autopsy? *Ind*What test confirmed diagnosis? *1. Spongy lungs*(Signed) *C. F. Connelley* M. D.1-29-22 Address *3701 1st St. N. W.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Woodlawn* DATE OF BURIAL *Jan 24 1922*20 UNDERTAKER *Chenoweth Son, Chestnut* ADDRESS *Ind*

D 60554

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60554

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

JAN 23 1922

ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, that I attended deceased from Jan 17, 1922, to Jan 21, 1922, that I last saw her alive on Jan 21, 1922, and that death occurred, on the date stated above, at 10:15 in. The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted If not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name organ); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior.*



# Alice Spencer

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60555

## CERTIFICATE OF DEATH.

D 60555

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 320 Worsley St. WARD 17)

## 2. FULL NAME

(a) RESIDENCE No. 320 Worsley St. WARD 17  
(Usual place of abode)Length of residence in city or town where death occurred 4 yrs. 0 mos. 0 ds.How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Wife6 DATE OF BIRTH (month, day, and year) Jan 18, 19227 AGE 44 Years 0 Months 0 Days If LESS than 1 day, 0 hrs. 0 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife 037(b) General nature of industry, business, or establishment in which employed (or employer) Home Wife

(c) Name of employer

9 BIRTHPLACE (city or town) live in Balt 4 years  
(State or country) born in Va10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Arnerline Sandridge14 Informant Mrs R A Elliott  
(Address) 1725 Ashlen Ave15 JAN 23 1922 ROBERT R. KRAUTER,  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/19 19 2217 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1921 to Jan 19, 1922, that I last saw her alive on Jan 18, 1922, and that death occurred, on the date stated above, at 12:00 a.m.

The CAUSE OF DEATH\* was as follows:

Acute Malignant EndocarditisCONTRIBUTORY (duration) 0 yrs. 0 mos. 0 ds.  
Acute Malignant Endocarditis  
(Secondary) (duration) 2 yrs. 1 mos. ? ds.18 Where was disease contracted?  
If not at place of death? XDid an operation precede death? No Date of 1.22Was there an autopsy? NoWhat test confirmed diagnosis? Physical Exam(Signed) W. S. Hall, M. D., 19 (Address) 1206 23 St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Mt. Auburn Cem

DATE OF BURIAL

20 UNDERTAKER

Mrs R A ElliottJan 22, 1922ADDRESS 1725Adland St

D 60556

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60556

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 S Rose St ST. 1 WARD)

## 2-FULL NAME

Albert F. Gull

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE, NO.

703 S. RoseST. 1

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 1/2 yrs. - mos. - ds.How long in U. S., if of foreign birth? - yrs. - mos. - ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Child

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

## 6 DATE OF BIRTH (month, day, and year)

Feb 21 - 1921

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

11-

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

## 10 NAME OF FATHER

John J. Gull

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md

## 12 MAIDEN NAME OF MOTHER

Elizabeth P. Gull

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md

## 14

Informant (Address)

John J. Gull  
703 S. Rose St

## 15

JAN 23, 1922 ROBERT R. KRAUTER, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22, 1922

## 17

I HEREBY CERTIFY, That I attended deceased from Jan 4, 1922 to Jan. 22, 1922, that I last saw him alive on Jan. 22, 1922and that death occurred, on the date stated above, at 12:35 p.m.

The CAUSE OF DEATH\* was as follows:

Diphtheria (Laryngeal)(duration) yrs. mos. 18 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

Diphtheria test

(Signed)

John H. Reiburger, M. D.

19 (Address)

1709 Alice Ave. N.W.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

St. Stanislaus Cemetery Jan. 23, 1922

## 20 UNDERTAKER

## ADDRESS

Stephen J. Galbowski1400 Wood

CAUSE OF DEATH in plain terms, so that it may be properly transcribed. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

St. Agnes Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.: 15

WARD)

2-FULL NAME

Naomi Beatrice Zellinger

(a) RESIDENCE. No.

Ellamonty Presbury ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1/18/22 (5.30 AM)

7 AGE

Years

Months

Days

If LESS than

day, hrs.

min.

4-15 1/2 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town, State or country)

Baltimore, Md

10 NAME OF FATHER

George Zellinger

11 BIRTHPLACE OF FATHER (city or town, State or country)

Baltimore, Md

12 MAIDEN NAME OF MOTHER

Sophie Blair

13 BIRTHPLACE OF MOTHER (city or town, State or country)

Louisville, Ky.

14

Informant (Address)

117 Columbia St.

15

JAN 24 1922

ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1/22/22

17

I HEREBY CERTIFY, That I attended deceased from

1/18/22

19

to 1/22/22

19

that I last saw her alive on 1/22/22

19

and that death occurred, on the date stated above, at 9 P.

The CAUSE OF DEATH was as follows

Cephal-hematoma

CONTRIBUTORY (Secondary)

Prolonged Labor

18 Where was disease contracted if not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

(Signed)

H. Harper

, 19

(Address)

St. Agnes Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Hull of Sam

1225 W. Pratt

D 60558 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60558

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE

No. 1741 Bank St.

ST. 2 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mary E. Cashmeyer

## (a) RESIDENCE. NO.

1741 Bank St.

ST. 2 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Widowed

6a If married, widowed, or divorced

HUSBAND of

Henry Cashmeyer

6 DATE OF BIRTH (month, day, and year)

Jan 9 1849

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

74

6

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

H. W. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

City

10 NAME OF FATHER

Joseph Finckland

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Margt. Werner

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Harry Cashmeyer 1741 Bank St.

15

Filed

JAN 23 1922

J. G. Moran

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 20 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 1, 1921, to Jan 20, 1922

that I last saw her alive on Jan 20, 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Arterio Sclerosis

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. G. Moran M. D.

1/23, 1922 (Address) 539 S. Ellwood St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Cem 1-24-22

20 UNDERTAKER

ADDRESS 3000

J. G. Moran 2 Baltimore

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60559

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 613 S. Smallwood ST. WARD)

2-FULL NAME

(a) RESIDENCE, NO. 613 S. Smallwood ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Wht.

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Louisa H. Behrmann

6 DATE OF BIRTH (month, day, and year)

Sept. 24 - 1899

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

72

3

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

Box Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Louisa H. Behrmann 613 S. Smallwood ST

15

Filed

19

JAN 23 1922

ROBERT E. KRAVITZ, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 20 1922

17

HEREBY CERTIFY, That I attended deceased from

Jan 20, 1922, Jan 20, 1922, that I last saw him alive on Jan 20, 1922

and that death occurred, on the date stated above, at 2:00 a.m.

The CAUSE OF DEATH\* was as follows:

Myocarditis Chronic Interstitial Nephritis

(duration)

yrs.

6 mos.

ds.

CONTRIBUTORY (Secondary)

Greener

(duration)

yrs.

4 mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bey D. McCarty, M. D.

(Address)

400 W. Bayson

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park

Jan 23 1922

20 UNDERTAKER

ADDRESS

George H. Schwab

2401 E. Pratt St.

D 60560

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 55' S Fulton Ave ST. 19 WARD)

2-FULL NAME

Edward H. McEoy

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 55' S Fulton Ave

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

Nov

30,

1922

(Month)

(Day)

(Year)

7-AGE,

yrs. 1 mos. 23 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country),

Balt City.

10-NAME OF FATHER,

Edward J. McEoy

11-BIRTHPLACE OF FATHER  
(State or Country),

Balt Md

12-MAIDEN NAME OF MOTHER

Ida C. Seitz

13-BIRTHPLACE OF MOTHER  
(State or Country),

Balt Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Edward J. McEoy

(Address)

55' S Fulton Ave

15-

Filed JAN 23 1922

ROBERT R. KRAUTER,

Burial Perms Registrar

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan

22,

1922

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Acute Lobar Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. Fenton M. D.

(Coroner.)

Jan 22 1922 (Address) 209 Chase St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the  
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Western Cemetery

Jan 23, 1922

20-UNDERTAKER

ADDRESS

George Schwab

2101 E. 11th Ave.

D 60561

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60561

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1575 Lemon

ST. 19 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Lelia Dixon  
1575 Lemon

ST. WARD.

(If nonresident give city or town and State)

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

12 - mos. 26 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Cauc

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year)

Dec. 24 1909

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

12 -

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child. odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

John Dixon

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Lizzie Dixon

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Lelia Hill  
1575 Lemon

15

Filed

JAN 23 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 20 1922

17 HEREBY CERTIFY. That I attended deceased from

Jan 8 1922 Jan 20 1922  
that I last saw him alive on Jan 20 1922and that death occurred, on the date stated above, at 11 P. M.  
The CAUSE OF DEATH\* was as follows:Pulmonary Phthisis  
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration)

yrs. mos. ds. 5 -

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Signed: J. H. Jones  
Address: 1313 N. North St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Auburn Cem.

DATE OF BURIAL

Jan 23rd 1922

20 UNDERTAKER

A. Jones

ADDRESS

207 S. Stricker St.

D 60562

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60562

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Riviera Apts.* ST. *13* WARD)2. FULL NAME *Jennie Goldsmith*(a) RESIDENCE NO. *Riviera Apts.* ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Lifetime* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of *Max E. Goldsmith*6 DATE OF BIRTH (month, day, and year) *Sept. 10, 1862*7 AGE Years *59* Months *4* Days *12* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at home*(b) General nature of industry, business, or establishment in which employed (or employer) *037*

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto. Md.* (State or country)10 NAME OF FATHER *Simon Greensfelder*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Schlosser*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)14 Informant *Max E. Goldsmith* (Address) *Riviera Apts.*15 Filed *JAN 23 1922* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 22 1922*17 I HEREBY CERTIFY, that I attended deceased from *Jan 19 1922* to *Jan 22 1922*, that I last saw her alive on *Jan 21 1922*, and that death occurred, on the date stated above, at *1 p.m.*

The CAUSE OF DEATH\* was as follows:

*Acute Cardiac Oil.*

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. P. Feltman* M. D.Address *1920 S. 1st St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Har Sinai Cem.*20 UNDERTAKER *David Sondheim*DATE OF BURIAL *1/24/1922*ADDRESS *118 W. Mt. Royal Ave.*

Information should be given in plain terms, so that it may be properly understood. See instructions on back of certificates.



D 60563

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60563

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE (No. 13 H Bruce)ST. 19

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## FULL NAME

Arthur Parker(Residence in Baltimore: No. 13 H Bruce)St. yrs., 2 mos. 33 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Colored5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

Dec311922

(Month)

(Day)

(Year)

7-AGE,

1 yrs. 2 mos. 23 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. none

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country), Bold & Ned

10-NAME OF FATHER,

Arthur Parker

11-BIRTHPLACE OF FATHER,

(State or Country), Maryland

12-MAIDEN NAME OF MOTHER

Myrtle Brown

13-BIRTHPLACE OF MOTHER,

(State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur Parker(Address) 13 H Bruce

15-

JAN 23 1922

191.

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan221922

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.)and that said deceased came to death (Inquest, autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH was as follows:

Robert Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. Keaton

(Coroner)

M. D.

Jan 22 1922 (Address) 107 E. Church

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. ZionJan 23 1922

20-UNDERTAKER

ADDRESS 114 W.Brown & Feilard

D 60564

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60564

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 Prestman ST., 15 WARD)

## 2-FULL NAME

Mildred Warner

## (a) RESIDENCE NO.

1625 Prestman

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Col.

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND or WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

Jan 16, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

at home

9 BIRTHPLACE (city or town) (State or country)

Balto City, Md

10 NAME OF FATHER

Jahn Warner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balt. Co., Md12 MAIDEN NAME OF MOTHER Octie Johnson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Co., Md

14

Informant

(Address) Octie Warner

15

Jan 23 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 20, 192217 I HEREBY CERTIFY That I attended deceased from January 16, 1922, to January 20, 1922, that I last saw her alive on January 20, 1922, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH\* was as follows:

Hæmorrhage of lungsTuberculosis of lungs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Lungs (duration) yrs. 4 mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Keyman, M. D.1-21, 1922 (Address) 708 E. 20th St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

mt Auburn Cemetery

20 UNDERTAKER

Edward Bryan

DATE OF BURIAL

23 Jan 22

ADDRESS

1631 Orleans

N. B.—WRITE PLAINLY, and be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 60565 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Hebrew Hospital*

CITY OF BALTIMORE: (No. \_\_\_\_\_)

ST., *1*

WARD)

2-FULL NAME

*Mrs Mary Strobel*(a) RESIDENCE No. *27 S Potomac*

(Usual place of abode)

ST., \_\_\_\_\_

WARD \_\_\_\_\_

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*F*

4 COLOR OR RACE

*white*

5 Single, Married, Widowed, or Divorced, (write the word)

*married*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

*Herman J Strobel*

6 DATE OF BIRTH (month, day, and year)

*Feb 23 1879*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*42**10**28*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*House work*

(b) General nature of industry, business, or establishment in which employed (or employer)

*037*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore*

10 NAME OF FATHER

*Anthony Strobel*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Baltimore*

12 MAIDEN NAME OF MOTHER

*Anna Kalbfleisch*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore*

14

Informant (Address)

*Herman J Strobel 27 S Potomac*

15

*JAN 23 1922*

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Jan 22 1922*

17

I HEREBY CERTIFY That I attended deceased from

*Dec 12 1921 to Jan 22 1922*

that I last saw him alive on

*Jan 22 1922*

and that death occurred, on the date stated above, at

*10 am*

The CAUSE OF DEATH\* was as follows:

*Hodgkins Disease*(duration) *5* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *0* Date of \_\_\_\_\_Was there an autopsy? *yes*

What test confirmed diagnosis?

*gland excision*(Signed) *Arthur J. Souders* M. D.

, 19 (Address)

*Hebrew Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Oak Lawn*

DATE OF BURIAL

*Jan 25 1922*

20 UNDERTAKER

ADDRESS

*John M. Weber**1803 Bank St*

Information should be carefully supplied in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

REGISTERED NO. C

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FILED JAN 23 1923

ROBERT R. KRAUTER,  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw h — alive on — 191 —

and that death occurred, on the date stated above, at 6:45 a.m.

The CAUSE OF DEATH\* was as follows:

(Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(Signed) — M. D.

Jan 20, 1923. (Address) — 626 N. Belmont

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N.B.—In case of death in plain terms, so that it may be properly recorded, the cause of death is important. See instructions on back of certificate.



HEALTH DEPARTMENT—CITY OF BALTIMORE  
D 60567

D 60567

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal HospitalST.: 76 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Dorsey(a) RESIDENCE. No. Unknown  
(Usual place of abode)

ST.: \_\_\_\_\_ WARD. \_\_\_\_\_

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18367 AGE Years 85 Months -- Days -- If LESS than 1 day, hrs. -- or min. --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.  
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown  
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)14 Informant Hospital Records,  
(Address) Municipal Hospital.15 Filed JAN 23 1922 ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17 19 2217 I HEREBY CERTIFY, That I attended deceased from  
January 16, 19 22, to January 17, 19 22.that I last saw him alive on January 17, 19 22.and that death occurred, on the date stated above, at 11:00 P.M.

The CAUSE OF DEATH\* was as follows:

uræmiaCONTRIBUTORY (Secondary) urinary obstruction  
(duration) yrs. mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there no autopsy?

What test confirmed diagnosis?

(Signed)

J. A. McKay, M. D.1/18/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

Information should be given in plain terms, so that it may be properly translated. CAUSE OF DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assoc.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Chronic  
Not nephritis.  
Obstruction probably  
due to hypertrophy  
of prostate. Man only  
in hosp. few hrs.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60568

## CERTIFICATE OF DEATH.

90 D 60568

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital

ST.: 17 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah West

(a) RESIDENCE. No. 415 New St.  
(Usual place of abode)

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
38 -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis,  
(State or country) Maryland

10 NAME OF FATHER Edward Lee

11 BIRTHPLACE OF FATHER (city or town) Unknown  
(State or country)

12 MAIDEN NAME OF MOTHER Laura Brown

13 BIRTHPLACE OF MOTHER (city or town) Maryland  
(State or country)14 Informant Hospital Records,  
(Address) Municipal Hospital.15 Filed JAN 23 1922 ROBERT E. KRAUTER, Registrar  
Social Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17 19 22

17 I HEREBY CERTIFY, That I attended deceased from January 16, 19 22, to January 17, 19 22, that I last saw her alive on January 16, 19 22, and that death occurred, on the date stated above, at 9:00 A.M.

The CAUSE OF DEATH\* was as follows:

Myocardial insufficiency  
over

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

1/17/22 Address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
**CERTIFICATE OF DEATH.**  
 [Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
 BY PHYSICIAN.

*Not Luetic*



N.B.—Every item of information should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. important.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60569

D 60569

## CERTIFICATE OF DEATH.

REGISTERED NO. C

### 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 131-W-20 ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### 2-FULL NAME

(Residence in Baltimore: No. 131-W-20 ST. 11 WARD)

St.; yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

#### 3-SEX

M

#### 4-COLOR OR RACE

C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

#### 6-DATE OF BIRTH

Unknown, 1 (Month) (Day) (Year)

#### 7-AGE

7 yrs. 7 mos. 7 ds.

If LESS than 1 day, hrs. or min.

#### 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Unknown  
(b) General nature of industry, business, or establishment in which employed (or employer). Unknown

#### 9-BIRTHPLACE, (State or Country),

Unknown

#### 10-NAME OF FATHER,

Unknown

#### 11-BIRTHPLACE OF FATHER (State or Country),

Unknown

#### 12-MAIDEN NAME OF MOTHER

Blanch Green

#### 13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

### 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

#### 15-

Filed 191

JAN 23 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

### CORONER'S CERTIFICATE OF DEATH.

#### 16-DATE OF DEATH

Jan 20, 1922 (Month) (Day) (Year)

#### 17-I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy, or inquiry.)

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Hereditary Syphilis  
(Duration) yrs. mos. ds.

#### CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.  
(Signed) John H. Morrison M. D.  
Address 3632 N. 6th St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

#### 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

#### Former or usual residence

#### 19-PLACE OF BURIAL, OR REMOVAL,

#### DATE OF BURIAL,

#### 20-UNDERTAKER

#### ADDRESS

D 60570

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

3302 Hudson

ST.

WARD)

## 2-FULL NAME

Charles Kraemer

## (a) RESIDENCE. NO.

3302 Hudson

ST.

WARD.

(If nonresident give city or town and State)

(Usual place of abode)  
Length of residence in city or town where death occurred

yrs.

mos.

29

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

June 23-1921

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

-

6

29

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore, Md.

## 10 NAME OF FATHER

George C. Kraemer

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Baltimore, Md.

## 12 MAIDEN NAME OF MOTHER

Nellie Green

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Baltimore, Md.

## 14

Informant  
(Address)

Nellie Kraemer

3302 Hudson St.

## 15

JAN 23 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan. 22 1922

## 17

I HEREBY CERTIFY, That I attended deceased from  
Jan 22, 1922, to Jan 22, 1922,  
that I last saw him alive on Jan 22, 1922,

and that death occurred, on the date stated above, at 7:25 P. m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) W. N. Schwaetka, M. D.

1/22 1922 Address 734 b Ellwood Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Mt. Carmel Cemetery

Jan 24 1922

## 20 UNDERTAKER

Fickler &amp; Pugh

ADDRESS 1739

E. J. Gager

N. B.—WRITE PLAINLY, WITH CARE. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 60571

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hollins Ferry Rd. Lakeland* ST. *135* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *Hollins Ferry Rd. Lakeland* ST. *135* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE,

*White*

## 5-SINGLE,

*Single*  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

## 6-DATE OF BIRTH,

*May 13, 1921*  
(Month) (Day) (Year)

## 7-AGE,

*8 yrs. 9 mos. 9 da.*

If LESS than 1 day,

...hrs. or ...m/u.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

*none*  
*000*

## 9-BIRTHPLACE,

(State or Country),

*Baltimore City*

## 10-NAME OF FATHER,

*Robert H. Haddon*

## 11-BIRTHPLACE OF FATHER

(State or Country),

*Baltimore*

## 12-MAIDEN NAME OF MOTHER

*Mable Margaret Haddon*

## 13-BIRTHPLACE OF MOTHER

(State or Country),

*Baltimore*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lakeland, James*(Address) *Robert H. Haddon*

15-

JAN 23 1922 ROBERT R. KRAUTER

Filed

191

Burial Permit *Class*

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan 22, 1922*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Jan 19, 1922, to Jan 22, 1922,*that I saw him alive on *Jan 22, 1922,*and that death occurred, on the date stated above, at *10:5 A.M.*

The CAUSE OF DEATH\* was as follows:

*Peritonitis from perforated intestine.*Swallowing foreign substance.  
(Duration) ... yrs. ... mos. ... da.  
CONTRIBUTORY (Secondary) *Stomach*

(Duration) ... yrs. ... mos. ... da.

(Signed) *James M. Lakeland, M.D.**Jan 22, 1922* (Address) *Lakeland*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the ... yrs. ... mos. ... da. State ...

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*London Park Cem Jan 24, 1922*

## 20-UNDERTAKER

## ADDRESS

*Schlossman Son Jan 21*

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

D 60572

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60572

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 907 Linden St. WARD 4)2. FULL NAME Rochel Thomas(a) RESIDENCE NO. 907 Linden St. WARD 4

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE Colored5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14

Informant (Address) Marion Gray  
907 Linden St.

15

JAN 23 1922

ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1922

17

HEREBY CERTIFY, That I attended deceased from Jan 10 1922 to Jan 20 1922that I last saw him alive on Jan 20 1922and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH\* was as follows:

Cancer of the liver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? YesDid an operation precede death? No Date of YesWas there an autopsy? NoWhat test confirmed diagnosis? None(Signed) A. R. Ellis

19

(Address) 527 Park

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Burial

St. John's Church1/23/22

FUNERAL

Rev. Mr. H. S. Smith 1835

ADDRESS

907 Linden St.

maison should be filled in plain terms, so that it may be properly understood. See instructions on back of certificates.



D 60573

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## PLACE OF DEATH

CITY OF BALTIMORE (No. *2836 E Balto*)ST. *6* WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Frederick Weide*(Residence in Baltimore: No. *2816 E Balto*)

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE,

*White*5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)  
*Widower*

6-DATE OF BIRTH,

*aug.**1875*

(Month)

(Day)

(Year)

7-AGE

*46**5**mos.**ds.*

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*Bookkeeper*  
*Kindle & Co.*  
*Schluenderberg*9-BIRTHPLACE.  
(State or Country).*Balto. Md.*

10-NAME OF FATHER,

*Jacob Weide*11-BIRTHPLACE OF FATHER  
(State or Country).*Germany*

12-MAIDEN NAME OF MOTHER

*Don't Know*13-BIRTHPLACE OF MOTHER  
(State or Country).*Holland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Adolph Weide*(Address) *2088 E. Chester St.*

15-

Filed *JAN 23 1922*ROBERT R. KRAUTER,  
Burial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

*Jan**21**1922*

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Chronic Inhibits*

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Wm. J. Insley* M. D.

(Coroner)

Address *4 E. 1st*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

*Immanuel Cemetery**Jan 24, 1922*

20-UNDERTAKER

ADDRESS

*Lilly & Zeller**4008 W. 40th*

N.B.—Every item of information given is important. See instructions on back of certificate.

D 60574

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60574

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 S. Wolf ST., 2 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Antoniana Garalska(a) RESIDENCE No. 307 S. Wolf ST., 2 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 40 mos. 40 ds. How long in U. S., if of foreign birth? 40 yrs. 40 mos. 40 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofNaworzyn Garalski6 DATE OF BIRTH (month, day, and year) Apr 13-18637 AGE Years 58 Months 9 Days 9 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)Waworzyn Garalski  
307 S. Wolf St15 23 1922Robert P. Harrison,

19

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 22 1922

17

I HEREBY CERTIFY, That I attended deceased from

1 1 1922 to 1 22 1922that I last saw her alive on 1 21 1922and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Carcinoma Liver Metastases(duration) 1 yrs. 6 mos. ds.CONTRIBUTORY  
(Secondary)(duration) 10 yrs. 10 mos. ds.

18 Where was disease contracted

if not at place of death? UnknownDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Observation(Signed) H B Titlow M. D.1/22, 1922 (Address) 315 S. Highland Ave

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MUNAL

DATE OF BURIAL

St. Stanislaus Bur. Jan 25, 1922

20 UNDERTAKER

ADDRESS

M. J. Sadowski, 400 S. Ann

D 60575 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60575

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital

CITY OF BALTIMORE: (No.

Green &amp; Lombard St. ST.: 21

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Milton Gambull.

(a) RESIDENCE. NO.

848 Eastland St.

ST..

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

colored

5 Single, Married, Widowed, or Divorced (write the word)

infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 2, 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

— 5. 20 —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Thomas Gambull

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Hattie Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14 Informant (Address)

Hattie Gambull  
848 Eastland St.

15 Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 1922

17 I HEREBY CERTIFY, That I attended deceased from

1/21/22, 19 to 1/21/22, 19  
that I last saw him alive on 1/20/22, 19

and that death occurred, on the date stated above, at 2:10 A. M.

The CAUSE OF DEATH\* was as follows:

Broncho-pneumonia

CONTRIBUTORY (Secondary) Strangulated Hernia  
(duration) yrs. mon. 16 ds.  
(duration) yrs. mon. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Jan 2, 1922

Was there an autopsy? yes

What test confirmed diagnosis? Physical signs &amp; symptoms

(Signed) Geo. E. Jones, M. D.

19 (Address) University Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Anthony Cemetery 1/24 1922

20 UNDERTAKER

Mrs. Gertrude H. Jones 206 R. Conroy

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates. TION is very important.

AN 831322

Burial Permit Clerk.

D 60576

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60576

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *27* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. (No. *217 S. Sharp* ST. *3* WARD. *3*)

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. If of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*Colored*

5 Single, Married, Widowed, or Divorced (write the word)

*Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Mrs. Mary Brown*

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*47* *6* *18*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Fla.*

10 NAME OF FATHER

*William Brown*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Richmond Va*

12 MAIDEN NAME OF MOTHER

*Nattie Brown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Inda*

14

Informant (Address)

*Mercy Hospital Records*

15

File

*Robert P. Harrison*

Registrar

Burial Permit Clerk.

16 DATE OF DEATH (month, day, and year)

*Jan 22 1922*

17

I HEREBY CERTIFY, That I attended deceased from *DEC 30*, 19*21*, to *Jan 22*, 19*22*.that I last saw him alive on *Jan 22*, 19*22*, at *7:17* a.m.

The CAUSE OF DEATH\* was as follows:

*Pneumonia*

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Mercy Hospital*

20 UNDERTAKER

*Commissioner Health,*

DATE OF BURIAL

ADDRESS

19

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.



D 60577 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60577

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital

CITY OF BALTIMORE: (No.

Lombard &amp; Jones

ST.: 17

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ernest Cunningham

(a) RESIDENCE, NO.

728 Pennsylvania Ave.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

3

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Negro

5 Single, Married, Widowed, or Divorced (write the word)

Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1880

7 AGE

Years

Months

Days

If LESS than 1 day,  $\frac{1}{2}$  hr. or min.

42.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

N. Carolina

10 NAME OF FATHER

John Cunningham

11 BIRTHPLACE OF FATHER (city or town)

N. Car.

(State or country)

12 MAIDEN NAME OF MOTHER

Jane Purcell

13 BIRTHPLACE OF MOTHER (city or town)

N. Car.

(State or country)

14

Informant (Address)

John Smith  
522 W. Biddle St.

15

Filed

Robert P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1/18

1922

17

I HEREBY CERTIFY, That I attended deceased from

1/10

1922, to

1/18/

1922.

that I last saw him alive on

1/18/22

1922.

and that death occurred, on the date stated above, at

1:45 P.M.

The CAUSE OF DEATH\* was as follows:

Cerebral Apoplexy (right Hemiplegia).

(duration)

yrs.

mos.

8

ds.

CONTRIBUTORY (Secondary)

Paralytic Stroke.

(duration)

yrs.

mos.

1 1/2

ds.

18 Where was disease contracted if not at place of death?

Outside

Did an operation precede death?

no

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. A. Holden

M. D.

, 19

(Address)

University Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

AN 23 1922 Burial Permit Clerk

D 60578 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60578

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 Euclid Ave., Tuxedo Park 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna Coale Lynch

(a) RESIDENCE. No. 610 Euclid Ave., Tuxedo Park WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 2 mos. 24 ds. How long in U. S. if of foreign birth? -- yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Divorced

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Francis J. Lynch

6 DATE OF BIRTH (month, day, and year) Oct. 28, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	2	24	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) Baltimore  
Maryland

10 NAME OF FATHER Joseph G. Coale

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Baltimore  
Maryland

12 MAIDEN NAME OF MOTHER Florence Myers

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Baltimore  
Maryland

14 Informant Joseph G. Coale

(Address) 610 Euclid Ave., Tuxedo Park

15 Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to Jan 22, 1922,

that I last saw him alive on Jan 22, 1922,

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? Gorham, Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? — Et. Sputum

(Signed) E. H. Duncan M. D.

19 (Address) 5106 York Road

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Loudon Park Cemetery

1/24/22

20 UNDERTAKER

ADDRESS

Henry W. Mears &amp; Son 805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be understood by the jury. See instructions on back of certificates.

AN 23 1922

D 60579

## HEALTH DEPARTMENT—CITY OF BALTIMORE 60579

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 S. Chaple.

ST.

WARD) ✓

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. 523 S. Chaple.

(Usual place of abode)

Length of residence in city or town where death occurred

Life mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

WARD.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1/21/22

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Frank Stokowski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Nikolaya Migkool

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Frank Stokowski 523 S. Chaple.

15

Filed

Robert P. Harrison.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1922, to Jan 22, 1922.

that I last saw her alive on Jan 21, 1922.

and that death occurred, on the date stated above, at 6:00 a.m.

The CAUSE OF DEATH\* was as follows:

Ingestion Bitch (about 6 hrs. gestation) 8 hours (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

523 S. Chaple

Did an operation precede death?

No

Was there an autopsy?

None

What test confirmed diagnosis?

Clinical Exam.

(Signed) Edward P. Smith, M. D.

Address 16 E. Preston St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary.

1/22

1922

20 UNDERTAKER

William Halkowski 168 E. Eastern

CAUSE OF DEATH in plain terms, so that it may be understood by the jury. See instructions on back of certificates. TION is very important.

N 23 1922

Burial Permit Clerk.

Y  
T  
E  
F  
A  
S

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60580

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 1

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Lilian Kuczenski

## (a) RESIDENCE.

No. 3005 Hudson

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 days

ds. How long in U. S. If of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

female

## 4 COLOR OR RACE

white

## 5 Single, Married, Widowed, or Divorced (write the word)

single

## 6a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Jan 7-1922

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

16

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

child 800

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

## 10 NAME OF FATHER

Harry Kuczenski

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

?

## 12 MAIDEN NAME OF MOTHER

Katie

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

?

## 14

Informant (Address)

John Kuczenski 3005 Hudson St.

## 15

Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan. 23 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan. 18<sup>th</sup>, 1922, to Jan. 23<sup>rd</sup>, 1922.that I last saw her alive on Jan. 23<sup>rd</sup>, 1922.and that death occurred, on the date stated above, at 12<sup>10</sup> P. M.

The CAUSE OF DEATH\* was as follows:

Abscess of breast  
Septicemia

(duration) yrs.

mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs.

mos. ds.

## 18 Where was disease contracted if not at place of death?

Home

Did an operation precede death?

Yes Date of Jan 18<sup>th</sup>

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed) Carl Holman M. D.

, 19 (Address)

Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

St. Stanislaus Church

Jan 24 1922

## 20 UNDERTAKER

## ADDRESS

Hepburn Falkowski 1001 N. E. St.

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

89 1099

Burial Permit Clerk.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No injury. Pyogenic  
bacterial cause of  
abscess.*

D 60581 HEALTH DEPARTMENT—CITY OF BALTIMORE 60581

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *15* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*George Stevenson (Stevens)*

## (a) RESIDENCE. No.

*3707 Springdale Ave.* ST. *15* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*Colored*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*unknown*

## 6 DATE OF BIRTH (month, day, and year)

*1866*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*56*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*St. Mary's County Md.*

## 10 NAME OF FATHER

*unknown*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

*unknown*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant (Address)

*Police*

## 15

Filed

*Robert P. Harrison,*

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *1-22-22*

## 17

I HEREBY CERTIFY, That I attended deceased from

*1-14*, 19 *22*, to *1-22*, 19 *22*.that I last saw him alive on *1-21*, 19 *22*.and that death occurred, on the date stated above, at *4 a* m.

The CAUSE OF DEATH\* was as follows:

*Haemaphysia (left)*(duration) yrs. mon. *7* ds.

## CONTRIBUTORY (Secondary)

*Broncho-Pneumonia*(duration) yrs. mon. *3* ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *Not as yet.*What test confirmed diagnosis? *Exam.*(Signed) *J. A. Holden* M. D., 19 (Address) *Univ. Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Assumps Md.**Jan 24 1922*

## 20 UNDERTAKER

## ADDRESS

*Richard H. Buckley**2046 Bay**2610 Burch*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

AN 23 1922

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Terminal hemorrhage.*  
*on 9-10-1910*

D 60582 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60582

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *111 Eberry* ST. *73* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. *111 Eberry* ST. *73* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *70* yrs.How long in U. S., if of foreign birth? *20* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, Divorced (write the word) *Married*6 If married, widowed, or divorced HUSBAND of (or) WIFE of *Mary Kocar*6 DATE OF BIRTH (month, day, and year) *Mar. 7, 1867*7 AGE Years *54* Months *10* Days *13* If LESS than 1 day, hrs. of min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Merchant*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Bohemia*10 NAME OF FATHER *James Kocar*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Bohemia*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Bohemia*14 Informant *Anna Geman* (Address) *111 Eberry St.*15 Filed *Robert P. Harrison* Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan. 20* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *Jan. 16*, 19 *22*, to *Jan. 20*, 19 *22*, that I last saw him alive on *Jan. 20*, 19 *22*, and that death occurred, on the date stated above, at *10 P. m.*The CAUSE OF DEATH\* was as follows:  
*Acute Dilatation of the Heart*  
*Chronic Interstitial Nephritis*  
(duration) yrs. mos. *10* ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *NO* Date of *NO*Was there an autopsy? *NO*

What test confirmed diagnosis?

(Signed) *William W. Ferry*, M. D., 19 (Address) *816 - Pennsylvania Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Holy Cross Cem.* DATE OF BURIAL *Jan. 23* 19 *22*

20 UNDERTAKER

*Margaret G. Flynn* ADDRESS *1422 Light St.*

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.

N 23 1922



D 60583

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60583

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1634 Belt Ave. ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Patrick Garrity

## (a) RESIDENCE. NO.

1634 Belt Ave. ST. 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds.How long in U. S. If of foreign birth? 50 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of

(or WIFE of)

Mary G. Garrity

## 6 DATE OF BIRTH (month, day, and year)

May 1854

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

66676869707172737475767778798081828384858687888990919293949596979899100101102103104105106107108109110111112113114115116117118119120121122123124125126127128129130131132133134135136137138139140141142143144145146147148149150151152153154155156157158159160161162163164165166167168169170171172173174175176177178179180181182183184185186187188189190191192193194195196197198199200201202203204205206207208209210211212213214215216217218219220221222223224225226227228229230231232233234235236237238239240241242243244245246247248249250251252253254255256257258259260261262263264265266267268269270271272273274275276277278279280281282283284285286287288289290291292293294295296297298299300301302303304305306307308309310311312313314315316317318319320321322323324325326327328329330331332333334335336337338339340341342343344345346347348349350

D 60584

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60584

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 204 W Franklin ST. WARD 11)2-FULL NAME Marie Shevallye(a) RESIDENCE NO. 204 W Franklin ST. WARD 11

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds.How long in U. S., if of foreign birth 10 yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND or (or) WIFE of John Shevallye6 DATE OF BIRTH (month, day, and year) March 10 18657 AGE Years 56 Months 10 Days 10 If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Matron(b) General nature of industry, business, or establishment in which employed (or employer) Palace Theatre(c) Name of employer Chas. J. Pa9 BIRTHPLACE (city or town) (State or country) Phila. Pa10 NAME OF FATHER Robert L. Jones11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila. Pa12 MAIDEN NAME OF MOTHER Eliza Sumner13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jersey

PARENTS

14 Informant (Address) Eliza C. Harrison  
904 N. Fulton Ave

15

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 192217 I HEREBY CERTIFY, That I attended deceased from Jan 22 1921 to Jan 21 1922that I last saw her alive on Jan 20 1922and that death occurred, on the date stated above, at 1-2 a.m.

The CAUSE OF DEATH\* was as follows:

Apoplexy. 2. Struck(duration) yrs. mos. ds. 1

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 118 Where was disease contracted if not at place of death? unknownDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Microscopic(Signed) Thomas Nelson M. D., 19 (Address) 1001 N. Fulton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Absecon N.J.Jan 21 1922

UNDERTAKER

ADDRESS

William Beck 302 E. North

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate. TION is very important.

23

Dr. Nelson 1001 N. Fulton Ave

# D 60585 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)  
Length of residence in city or town where death occurred

yrs.

mos.

ds.

Now long in U. S., if of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from  
Dec 30, 1921, to Jan 22, 1922,  
that I last saw him alive on Jan 22, 1922,  
and that death occurred, on the date stated above, at 6.55 P. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Jaundice  
duration About 3 mos.  
CONTRIBUTORY Convulsions  
(Secondary) (duration) yrs. mos. 12

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Geo. Heeler M. D.  
(Address) 1327 937 W. 13th St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

15

Informant  
(Address)ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk.

JAN 24 1922

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates. TION is very important.

D 60586

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

(or) WIFE of

David King

6 DATE OF BIRTH (month, day, and year)

April 16 1981

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

40

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

Home

(c) Name of employer

9 BIRTHPLACE (city or town)

Raleigh, N.C.

10 NAME OF FATHER

Yusef Smith Raleigh

11 BIRTHPLACE OF FATHER (city or town)

N.C.

(State or country)

12 MAIDEN NAME OF MOTHER Selma Broughton

13 BIRTHPLACE OF MOTHER (city or town)

Raleigh

(State or country)

14 Informant Mrs. J. G. Love

(Address) 4800 Madison Ave.

15 JAN 24 1922 ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 23 1922, to Jan 23 1922

that I last saw him alive on Jan 23 1922

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH\* was as follows:

Pregnancy

CONTRIBUTORY (duration) yrs. 9 mos. ds.

Placenta Previa Central Death

18 Where was disease contracted 3814 Woodlawn Ave

If not at place of death? 4800 Madison Ave Date of Jan 23 1922

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Stanley W. Matthews M. D.

19 (Address) Maryland General Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery Jan 26 1922

20 UNDERTAKER E. E. E. 1723 N. E. Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60587

## CERTIFICATE OF DEATH.

35 D 60587  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 Annapolis Ave. ST. 35th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Violet May Taylor (Reported as Violet Fox)(Residence in Baltimore: No. 9 Annapolis Ave. West ST. 35th WARD yrs. 11 mos. 14 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, white 5-SINGLE, Single  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)6-DATE OF BIRTH, August 8, 1910  
(Month) (Day) (Year)7-AGE, 11 yrs. 5 mos. 14 ds. If LESS than 1 day,  
....hrs. or....min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work School girl  
(b) General nature of industry, business, or establishment in which employed (or employer) 0009-BIRTHPLACE, (State or Country), Chicago Ill.10-NAME OF FATHER, Edwin C. Taylor11-BIRTHPLACE OF FATHER (State or Country), Annapolis12-MAIDEN NAME OF MOTHER May E. Ward13-BIRTHPLACE OF MOTHER (State or Country), Talbot Co. Md.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph B. Fox(Address) Annapolis Road15- JAN 24 1922 ROBERT R. KRAUTER,  
Filed..... 191.....Burial Permit 000000

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 23, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Jan 9, 1922 to Jan 22, 1922,  
that I saw him alive on Jan 22, 1922,  
and that death occurred, on the date stated above, at 5:09 A.M.The CAUSE OF DEATH\* was as follows:  
Tubercular Meningitis  
(Duration).....yrs.....mos.....ds. 18CONTRIBUTORY Dis. of the articular  
(Secondary) Left hip (Duration).....yrs.....mos.....ds. 5  
(Signed) Thauren C. Meekins M. D.  
Jan 23, 1922 (Address) Baltimore

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Oliver Cemetery DATE OF BURIAL, Jan 25, 192220-UNDERTAKER John J. Brown & Son ADDRESS 200 Madison St.

CAUSE OF DEATH IN PARTS OF CERTIFICATE. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60588

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

ST.: \_\_\_\_\_

WARD) \_\_\_\_\_

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Boy Gibson

## (a) RESIDENCE, NO. \_\_\_\_\_

225 N. Durham

ST.: \_\_\_\_\_

WARD. \_\_\_\_\_

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

1 yr.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Black

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

1-11-22

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

10

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

## 10 NAME OF FATHER

Walter Gibson

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

## 12 MAIDEN NAME OF MOTHER

Frances Banks

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

## 14

Informant (Address)

## 15

FILE

JAN 24 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

1-22 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

1-21, 1922, to 1-22, 1922,

that I last saw him alive on 1-22, 1922,

and that death occurred, on the date stated above, at 9:55 am.

The CAUSE OF DEATH\* was as follows:

Prematurity

(duration) yrs. mos. 2 ds.

## CONTRIBUTORY (Secondary)

Malaria Remittens

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death? 225 N. Durham St. Balt.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) T. A. Gay, M. D.

19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

## 20 UNDERTAKER

## ADDRESS

Commissioner Health.

JAN 24 1922

D 60589

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

179 D 60589  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE (NO. *Franklin Square Hospital* ST. *70* WARD)2-FULL NAME *Thelma G. Brown*(Residence in Baltimore: No. *307 S. Pulaski*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *single* (Write the word.)6-DATE OF BIRTH, *Aug 17, 1886*  
(Month) (Day) (Year)7-AGE, *35 yrs. 5 mos. 4 ds.* If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *none*  
(b) General nature of industry, business, or establishment in which employed (or employer), *none*9-BIRTHPLACE, (State or Country), *Balt. City*10-NAME OF FATHER, *Lloyd J. Brown*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER, *Sarah F. McKee*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lloyd J. Brown*(Address) *307 S. Pulaski St.*15-  
JAN 24 1922

ROBERT R. KRAUTER,

Burlat Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 23, 1922*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, au-*inquest* and that said deceased came to *death* (topsy or inquiry.) on the day stated above.The CAUSE OF DEATH\* was as follows:  
*30 hours over 24 hrs. for*  
*fatal flame accident,*  
*chlorine caught from gas*  
*hester* (Duration) *6* yrs. *6* mos. *6* ds.

CONTRIBUTORY (Secondary)

(Signed) *James M. Benton* M. D.  
(Coroner.)*Jan 24, 1922* (Address) *709 E. Chas. St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, *6* yrs. *6* mos. *6* ds. In the State, *6* yrs. *6* mos. *6* ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Western Cemetery* DATE OF BURIAL, *Jan 24, 1922*20-UNDERTAKER, *H. H. White* ADDRESS, *1501 W. Lombard St.*N.B.—Every item of information should be in plain terms, so that it may be properly classified.  
CAUSE OF DEATH in plain terms, so that it may be properly classified.  
important. See instructions on back of certificate.

D 60590

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1005 N Stricker*ST. *16* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Richard Johnson*(Residence in Baltimore: No. *1005 N Stricker*St. *13* yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *Sept*, *1890*

(Month)

(Day)

(Year)

7-AGE *31* yrs. *4* mos. ds.

If LESS than 1 day, ...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Laborer*  
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *Balt 13 years*

## PARENTS.

10-NAME OF FATHER, *Not known*11-BIRTHPLACE OF FATHER (State or Country), *Not known*12-MAIDEN NAME OF MOTHER *Not known*13-BIRTHPLACE OF MOTHER (State or Country), *Not known*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Rosie Johnson*(Address) *1005 N Stricker St*

## 15-

Filed: *JAN 24 1922*

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 21st*, *1922*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Dec 5th* *1921* to *Jan 21st* *1922*.that I saw him alive on *Jan 21st* *1922*.and that death occurred, on the date stated above, at *6P* m.

The CAUSE OF DEATH\* was as follows:

*Mitral Regurgitation of heart*(Duration) *3* yrs. *2* mos. *2* ds.

## CONTRIBUTORY (Secondary)

(Duration) *not known*(Signed) *Harry J. Brown*, M. D.*Jan 13 1922* (Address) *1501 Pressman*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Mt. Auburn Cem*DATE OF BURIAL, *Jan 24, 1922*

## 20-UNDERTAKER

ADDRESS *1725-**Mrs. Robert A. Elliott Ashland St*

CAUSE OF DEATH in plain text, so that it may be important. See instructions on back of certificate.



D 60591

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60591

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No

16328 Madison ST.

WARD) 7

## 2-FULL NAME

Morton Vessell

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

16328 Madison ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced (Write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

1857

7 AGE

65

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Freight (Labour)

(b) General nature of industry, business, or establishment in which employed (or employer)

Freight-Labour Penna R.R.

(c) Name of employer

9 BIRTHPLACE (city or town)

Baltimore, Md.

10 NAME OF FATHER

Chas Vessell

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

Elizabeth L. Tolson 505 Mosher St

15

JAN 24 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 23 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 18

1922

to Jan 23

1922

that I last saw him alive on

Jan 22

1922

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) F. L. Smith, M. D.

(Address) 1313 N. North St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn Cem

Jan 25 1922

20 UNDERTAKER

Mrs Robert A. Elliott

ADDRESS 725-

Ashland St.

D 60592

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60592

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 2011 McKean Ave. ST. 15 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

William C Harrington

## (a) RESIDENCE. NO.

2011 McKean Ave. ST. 15 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

15 yrs

mos.

da.

How long in U. S., if of foreign birth?

yrs.

mos.

da.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of

Annie Harrington

## 6 DATE OF BIRTH (month, day, and year)

1884

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

63

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Manager 1886

(b) General nature of industry, business, or establishment in which employed (or employer)

Motion Picture

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Pa.

## 10 NAME OF FATHER

Thos. Harrington

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Delaware

## 12 MAIDEN NAME OF MOTHER

Edie Brundge

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa.

## 14

Informant (Address)

Annie Harrington 2011 McKean Ave.

## 15

Filed

JAN 24 1922

Registrar

J. E. Hahn

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan 23

1922

## 17

HEREBY CERTIFY, That I attended deceased from

Jan 11, 1922, to

Jan 23, 1922,

that I last saw him alive on

Jan 22, 1922,

and that death occurred, on the date stated above, at

720 A. M.

The CAUSE OF DEATH\* was as follows:

Angina Pectoris

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. 12 da.

Arterial Sclerosis

(duration) yrs. mos. da.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Physical

(Signed)

J. Burch Joyce, M. D.

19

(Address)

1800 W. North Ave.

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

London Park

Jan 25 1922

## 20 UNDERTAKER

## ADDRESS

Martin F. Hahn 1800 W. North Ave.

D 60593

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

154-002  
D 60593

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 Sterrett ST., 21 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Elmer F. Sellers

## (a) RESIDENCE NO.

1123 Sterrett

ST., \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 6a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Jan 18 1922

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.  
6

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Balti

## 10 NAME OF FATHER

William D. Sellers

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balti

## 12 MAIDEN NAME OF MOTHER

Lillian Parker

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balti

## 14

Informant (Address)

William D. Sellers  
1023 Sterrett St

## 15

Filed

JAN 24 1922Helkehn Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-24-1922

17

I HEREBY CERTIFY, That I attended deceased from

1-23- 1922, to 19.that I last saw him alive on 1-24-22 19and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH\* was as follows:

Failure of Forebrain Ovary to evolve(duration) yrs. mos. 6 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. L. D. D. M. D., 19 (Address) 227 Calverton

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Western CemeteryJan 24 1922

## 20 UNDERTAKER

## ADDRESS

James F. F. Son1005 S. Paca St

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

D 60594 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60594

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 246 N Bruce ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Henry Noakes

(a) RESIDENCE. No. 246 N Bruce ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE A 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of Susan Noakes (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 22, 1878

7 AGE Years 43 Months 4 Days 29 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Dealer (b) General nature of industry, business, or establishment in which employed (or employer) Selling &amp; Handling Coal (c) Name of employer Self

9 BIRTHPLACE (city or town) Va Co. Md. (State or country)

10 NAME OF FATHER Lloyd Noakes

11 BIRTHPLACE OF FATHER (city or town) Aaco. Md. (State or country)

12 MAIDEN NAME OF MOTHER Anna George

13 BIRTHPLACE OF MOTHER (city or town) Aaco. Md. (State or country)

14 Informant: Susan Noakes (Address) 246 N Bruce St

15 Filed 19 1922 Registrar J. E. Wehn

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1922, to Jan 21, 1922, that I last saw him alive on Jan 21, 1922, and that death occurred, on the date stated above, at 1:25 A.M.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Physical &amp; Spinal

What test confirmed diagnosis?

(Signed) William H. Hanger, M. D.

(Address) 1709 P. N. Avenue St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St Marks Cemetery Jan 24 1922

20 UNDERTAKER ADDRESS

Edward Hargold 1463 Ave

CAUSE OF DEATH in plain terms, so that it may be put on back of certificate. See instructions on back of certificates.



# HEALTH DEPARTMENT CITY OF BALTIMORE

D 60595

## CERTIFICATE OF DEATH.

44 D 60595

### PLACE OF DEATH

CITY OF BALTIMORE (No. 1805 Street St)

2-FULL NAME Joseph Slady

(Residence in Baltimore: No. 1805 Street St)

REGISTERED NO. C

ST. 2 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 15 mos. da.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Married

6-DATE OF BIRTH, Dec 11, 1870 (Month) (Day) (Year)

7-AGE, 52 yrs., 1 mos., 12 da. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Saloon

9-BIRTHPLACE, (State or Country). Poland

10-NAME OF FATHER, Michael Slady 11-BIRTHPLACE OF FATHER, (State or Country). Poland 12-MAIDEN NAME OF MOTHER, Agatha Zawacki 13-BIRTHPLACE OF MOTHER, (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Joseph Slady (Address) 1805 Street St

15- JAN 8 4 1922 101 Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 23, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows: Carcinoma of Stomach

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. da. (Signed) Harry G. M. D. (Coroner) 1805 Street St (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death yrs. mos. da. In the State yrs. mos. da. Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary Jan 25 1922 DATE OF BURIAL,

20-UNDERTAKER, John M. Weber 1803 Bank ADDRESS

N.B.—Every item of information should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

60596

D 60596 CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Jarvis(a) RESIDENCE. No. 1122 Russell st.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 18987 AGE Years Months Days If LESS than 1 day, hrs. or min. 23

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) (State or country) Virginia10 NAME OF FATHER John Jarvis11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown14 Informant Hospital Records (Address) M. T. H.15 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21, 192217 I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1921 to Jan. 21, 1922that I last saw him alive on Jan. 20, 1922and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray(Signed) Francis L. Badalosso M. D.1-21-22 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

Commissioner HealthJAN 24 1922

Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## D 60597

### CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 22 WARD)2-FULL NAME Brige Sales(a) RESIDENCE. NO. 530 W. Lee St ST. 22 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----6 DATE OF BIRTH (month, day, and year) 19877 AGE Years Months Days If LESS than 1 day, hrs. or min. 24 -- -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Hospital Records, Johns Hopkins Hospital.

15 Filed

JAN 24 1922ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 19 2217 I HEREBY CERTIFY, That I attended deceased from January 11 19 22, to January 21 19 22, that I last saw him alive on January 20 19 22, and that death occurred, on the date stated above, at 9 A.M. m. The CAUSE OF DEATH\* was as follows:Lobar pneumonia(duration) yrs. mos. ds. 8

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. E. McNeil M. D.1/21/22 Address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

Commissioner Health.

ADDRESS

19

D 60598

body sent to city morgue  
HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE (No. 721 Raborg St

St.:

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 721 Raborg St -

St.: yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Black

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Style

6-DATE OF BIRTH,

Don't know

(Month)

(Day)

(Year)

7-AGE,

42

yrs.

mos.

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

9-BIRTHPLACE,

(State or Country),

Baltimore

10-NAME OF FATHER,

Don't know

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

15-

JAN 24 1922

191

ROBERT R. KRAUTER

Burial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan

12

1922

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cerebral apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't know

(Duration) yrs. mos. ds.

(Signed) M. D.

1/12, 1922 (Address) 117 N. Main St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER ADDRESS

JAN 2 1922



N. B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60599

## CERTIFICATE OF DEATH.

163 D 60599

### PLACE OF DEATH

CITY OF BALTIMORE (No. *939 n chapel st.*)

2-FULL NAME

*Beyner Blench Branch.*

(Residence in Baltimore: No. *939 n chapel st.*)

REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>Male</i>	4-COLOR OR RACE, <i>col.</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <i>Mar.</i>
6-DATE OF BIRTH, <i>Sept 5, 1911</i> (Month) (Day) (Year)		
7-AGE, <i>4 yrs. 12 mos. 12 ds.</i> If LESS than 1 day, ... hrs. or ... min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		
9-BIRTHPLACE, (State or Country), <i>Balto</i>		
PARENTS.	10-NAME OF FATHER, <i>Harry Delaney.</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>Va</i>	
	12-MAIDEN NAME OF MOTHER <i>Walle Branch.</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Va.</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

ROBERT R. KRAUTER,

Burial Permit Clerk.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Mnth)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

opsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Lack of care.*

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Coroner)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

1911

JAN 2 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60600

## CERTIFICATE OF DEATH.

179 D 60600

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1137 Parish ST. 16 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Nickolas Mercer Smallwood(a) RESIDENCE NO. 1137 Parish ST. 16 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? 46 yrs. 4 mos. 4 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) Elyza Smallwood6 DATE OF BIRTH (month, day, and year) May 31, 19667 AGE Years 55 Months 9 Days 8 If LESS than 1 day, hrs. 8 or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor 670(b) General nature of industry, business, or establishment in which employed (or employer) Attending Surgeon(c) Name of employer Kennel Hotel9 BIRTHPLACE (city or town) West River (State or country) Ind.10 NAME OF FATHER Eli Smallwood11 BIRTHPLACE OF FATHER (city or town) West River (State or country) Ind.12 MAIDEN NAME OF MOTHER Sophie Dorsey13 BIRTHPLACE OF MOTHER (city or town) West River (State or country) Ind.14 Informant Elyza Smallwood (Address) 1137 Parish St.15 JAN 24 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 192217 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1921 to Jan 22, 1922that I last saw him alive on Jan 21, 1922and that death occurred, on the date stated above, at 1:45 P. M.

The CAUSE OF DEATH\* was as follows:

Acute Nephritis(duration) 6 yrs. 6 mos. 4 ds.CONTRIBUTORY (Secondary) Heart(duration) 1 yrs. 1 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of NoWas there an autopsy? NoWhat test confirmed diagnosis? Urinary(Signed) William F. Gray M. D.1/23, 1922 (Address) 1928 Penna Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
BURYAL St. Luke's Cemetery DATE OF BURIAL 25 192220 UNDERTAKER Wm. D. Lewis ADDRESS 303St. Luke's Cemetery21

mation should be carefully supplied so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Acute attack of chronic condition. Arteriosclerosis. No hemorrhage. No further history.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60601

D 60601

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

REGISTERED NO.

CITY OF BALTIMORE: (No. 1315 Eden

ST. 9

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 1315 Eden

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced (write the word)

man

White

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan. 24-1894

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

27

11

29

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Machinist

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

Elgin motor co

9 BIRTHPLACE (city or town)  
(State or country)

Md

10 NAME OF FATHER

George E. Eitz

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balt

12 MAIDEN NAME OF MOTHER

Louise Blatkauf

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant  
(Address)

Mrs Louise Eitz

1315 N. Eden St

15

JAN 24 1922

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 22 1922

17

I HEREBY CERTIFY, That I attended deceased from  
Jan 1 1922, to Jan 22 1922

that I last saw him alive on

Jan 22 1922

and that death occurred, on the date stated above, at

8.10 A.M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. da.

Coronary Artery

(duration) yrs. mos. da.

18 Where was disease contracted

if not at place of death?

?

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed) Willam J. Ryan, M. D.

19 (Address) 801 N. Enoch

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Cemetery

Jan 25 1922

20 UNDERTAKER

ADDRESS

George F. Reith 735 Haywood

Information should be given in plain terms, so that it may be properly understood. CAUSE OF DEATH is very important. See instructions on back of certificates.



HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60602

CERTIFICATE OF DEATH.

D 60602

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 Woodley

ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida M. Richter

(a) RESIDENCE. NO. 1014 Woodley

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

hrs.

mos.

ds.

How long in U. S., if of foreign birth?

hrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Albert Richter

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

47

47

11

28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md.

10 NAME OF FATHER

Aug. Bongdman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Don't know

12 MAIDEN NAME OF MOTHER

Julia Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind

14

Informant (Address)

Albert Richter 1014 Woodley

15

FILED JAN 24 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-23 1922

17

I HEREBY CERTIFY, that I attended deceased from July 1921 to Jan 23, 1922, that I last saw her alive on Jan 23, 1922, and that death occurred, on the date stated above, at 10:10 P. M.

The CAUSE OF DEATH\* was as follows:

Myocardial degeneration Pulmonary Tuberculosis?

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

Asthma

(duration) yrs. 1 mos. ds.

18 Where was disease contracted? If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Guy D. Cherry M. D. 1/24/22 Address 400 N Payson St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mrs Woodlawn

1-25 1922

UNDERTAKER

Mrs Charles G. Rohde 600 N. Calvary St

D 60603 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60603

CERTIFICATE OF DEATH.

1-PLACE OF DEATH  
CITY OF BALTIMORE (No. *736 Pacific Ave* ST. *13* WARD)  
2-FULL NAME *John R. Hitchfield*  
(Residence in Baltimore: No. *736 Pacific Ave*)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: *52* yrs., *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *M.* 4-COLOR OR RACE, *W.* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*  
(Write the word.)

6-DATE OF BIRTH, *April 24, 1847*  
(Month) (Day) (Year)

7-AGE, *74* yrs. *9* mos. *—* ds. If LESS than 1 day, *—* hrs. or *—* min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *Woodworker*  
(b) General nature of industry, business, or establishment in which employed (or employer), *OSB*

9-BIRTHPLACE, *Wales, Howland Co.*  
(State or Country).

10-NAME OF FATHER, *John Hitchfield*

11-BIRTHPLACE OF FATHER, *W. Va.*  
(State or Country).

12-MAIDEN NAME OF MOTHER, *May Weaver*

13-BIRTHPLACE OF MOTHER, *W. Va.*  
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Margaret Hitchfield*  
(Address) *736 Pacific Ave.*

15- *Robert F. Harrison,*

241922 Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 22, 1902*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, and that said deceased came to death thereon and from the evidence obtained by said inquest, and

And that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

*Heart disease*  
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *John Harrison* M. D.  
(Coroner) *Jan 22, 1902* Address *732 Polk Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *London Park* DATE OF BURIAL, *Jan 26, 1902*

20-UNDERTAKER, *George Smith* ADDRESS *W. Va.*

D 60604

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60604

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 Calender ST. 18 WARD)

## 2-FULL NAME

(a) RESIDENCE. NO. 104 Calender ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 3 mos.

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Robert P. Harrison, Registrar

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 20, 1922, to Jan 20, 1922.

that I last saw him alive on Jan 20, 1922.

and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH\* was as follows:

Tubercular Meningitis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Jan 23 1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

N 84 1922

Burial Permit Clerk.

15-3316  
D 60605

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60605

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Andrew Faulkner

## (a) RESIDENCE. NO.

Cass W Va

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Jessie Faulkner

6 DATE OF BIRTH (month, day, and year)

Unknown 1883

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

38

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

?ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Gapp Mills W Va

10 NAME OF FATHER

R H Faulkner

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Gapp Mills

12 MAIDEN NAME OF MOTHER

Ellen Hinkle

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Cherry Co. W. Va.

14

Informant (Address)

Robert P. Harrison,

15

Filed

19

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-24 1922

17

I HEREBY CERTIFY, That I attended deceased from

1-20, 1922, to 1-24, 1922that I last saw him alive on 1-24, 1922and that death occurred, on the date stated above, at 3:42 a m.

The CAUSE OF DEATH\* was as follows:

Brain Tumor(duration) yrs. 11 mos. 23 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

at home - St. Louis Mo

Did an operation precede death?

Date of 1/22/22 & 1/23/22

Was there an autopsy?

yes

What test confirmed diagnosis?

operation & x-rays

(Signed)

George H. Gardner, M. D.

19 (Address)

Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Remick West Va

DATE OF BURIAL

Jan 24 1922

20 UNDERTAKER

Joseph Shrews

ADDRESS

2218 Bway

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.



D 60606

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60606

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2442 Callow ave.

ST. 13<sup>th</sup> WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adele Nusbaum

(a) RESIDENCE. No. 2442 Callow ave.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs.

mos.

ds.

How long in U. S. If of foreign birth? 00 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 1 1836

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

87

5

23

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Alsace France

10 NAME OF FATHER

Abraham Bloch

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Alsace France

12 MAIDEN NAME OF MOTHER

Fanny Bloch

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Alsace France

14

Informant (Address)

Simon Nusbaum 2442 Callow ave

15

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 8<sup>th</sup>, 1922, to Jan 23, 1922, that I last saw her alive on Jan 23, 1922, and that death occurred, on the date stated above, at 9:00 p. m.

The CAUSE OF DEATH\* was as follows:

Bronchial Asthma  
High Blood Pressure  
\* Apoplexy during -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? \* Urinalysis

(Signed) Dr. J. H. H. M. D.

124, 1922 Address # 1111 1111 St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Frenshick

Jan 25 1922

20 UNDERTAKER

ADDRESS

J. Ahrens &amp; Co

1611 North Ave

D 60607

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60607

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

513 Willow Ave

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Blanche Louise Maenner

## (a) RESIDENCE. No.

513 Willow Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced — HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Sept - 1913.

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

9

4

7

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Lauraville Md

## 10 NAME OF FATHER

John F Maenner

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

## 12 MAIDEN NAME OF MOTHER

Nettie Brockmeyer

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

## 14

Informant (Address)

Sister Blanche

## 15

Filed

Robert P. Harrison,

19

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan 24 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan 5 1922, to Jan 24 1922

that I last saw her alive on Jan 24 19

and that death occurred, on the date stated above, at 5 20

The CAUSE OF DEATH\* was as follows:

Post dysenteric cardiac paralysis

(duration)

yrs.

mos.

1 X ds.

## CONTRIBUTORY (Secondary)

Endocarditis

(duration)

yrs.

mos.

4 ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Clinical Evidence

(Signed)

H. W. Wharton

M. D.

, 19

(Address)

4235 York Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Holy Redeemer Jan 28 1922

## 20 UNDERTAKER

## ADDRESS

Wm Cook &amp; Co 8 North

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.

N 24 1922

REVISED UNITED STATES STANDARD  
**CERTIFICATE OF DEATH.**  
 [Approved by U. S. Census and American Public Health Asso.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
 BY PHYSICIAN.

*Dr. Wheaton not in attendance  
 when child had diphtheria.  
 To be charged to diphtheria.  
 Dr. Hogan states.*

D 60608

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60608

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 101 N. Clement ST.: 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Morrisette(a) RESIDENCE. No. 101 N. Clement ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22 1922

7 AGE Years Months Days If LESS than 1 day 10 hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md10 NAME OF FATHER Julian H Morrisette11 BIRTHPLACE OF FATHER (city or town) (State or country) Hampton Va12 MAIDEN NAME OF MOTHER Estelle M. McCurdy13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md14 Informant Julian Morrisette (Address) 101 N. Clement St

JAN 24 1922

Robert F. Harrison,

Burial Permit Clerk.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 19 2217 I HEREBY CERTIFY, That I attended deceased from Jan 22 19 22 to Jan 23 19 22that I last saw her alive on Jan 22 19 22and that death occurred, on the date stated above, at 9.15 A. m.

The CAUSE OF DEATH\* was as follows:

Myocardial CoronaryArteryCONTRIBUTORY (Secondary) Primaire Heart

(duration) yrs. mos. ds. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Morrisette M. D.1922 (Address) 1274 William St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Patrick's Cem. DATE OF BURIAL Jan 24 19 22

20 UNDERTAKER

Margaret G. Flynn ADDRESS 1427 Light St



D 60609

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 60609

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *10*)

## 2-FULL NAME

(a) RESIDENCE. NO. *1108 Hartford St.*

(Usual place of abode)

Length of residence in city or town where death occurred *65* yrs. *4* mos. *8* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *DEC 15 1856* 7 AGE *65* Years *1* Months *8* Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore, Md.*10 NAME OF FATHER *Thomas Doyle*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore, Md.*12 MAIDEN NAME OF MOTHER *Margaret Doyle*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore, Md.*14 Informant (Address) *Mercy Hospital*

15

Robert F. Harrison, Registrar

N 24 1922

Baptist Permit Clerk

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD)

WARD.

(If nonresident give city or town and State)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 23 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan 7 1922* to *Jan 23 1922*that I last saw him alive on *Jan 23 1922*and that death occurred, on the date stated above, at *1:20 P.M.*

The CAUSE OF DEATH was as follows:

*Probable apoplexy (removal of blood)*CONTRIBUTORY (Secondary) *hypertensive disease*

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *John P. Brown, M.D.*19 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Cathedral Cem.*20 UNDERTAKER *Margaret G. Flynn*DATE OF BURIAL *Jan 24 1922*ADDRESS *1422 Light St.*

D 60610

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60610

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1530 Byrd

ST.: 24 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Charles James, Jr

## (a) RESIDENCE. NO. 1530 Byrd

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 20/21

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

3

4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant, 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore, Md

10 NAME OF FATHER

Chas. James, Jr

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Md

12 MAIDEN NAME OF MOTHER

Mary Butz

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md

14

Informant  
(Address)Charles James, Jr  
1530 Byrd St

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/24 1922

17 I HEREBY CERTIFY, That attended deceased from 1/16/22 to 1/24/22 that I last saw him alive on 1/24/22 and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

19 (Address)

1319 Light St

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore, Md

Jan 25-22

20 UNDERTAKER

ADDRESS

Margaret A. Flynn

1422 Light St

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior.*

D 60611 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60611

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 810 N. 36th St.

ST. 13 WARD

## 2-FULL NAME

Joseph R. Knight

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

810 N. 36th St.

ST. 13 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widower

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Margaret Ellen Knight

6 DATE OF BIRTH (month, day, and year)

July 12-1888

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

83

6

10

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Bailliff Orphans Court

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired 9 years

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore, Md.  
Maryland

10 NAME OF FATHER

Horace Knight

11 BIRTHPLACE OF FATHER (city or town)

Baltimore, Md.

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Katherine Gambrell

13 BIRTHPLACE OF MOTHER (city or town)

Maryland

(State or country)

14

Informant  
(Address)C. Frank Knight  
810 N. 36th St.

15

Robert P. Harrison,

19

Burial Permit Clerk.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan. 22, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 16, 1922, to Jan 22, 1922,

that I last saw him alive on Jan 22, 1922,

and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH\* was as follows:

Erysipelas

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Hypertension (long)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

Typhoid fever

(Signed) R. E. Norment, M. D.

1922 (Address) 384 Chestnut Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St. Mary's (Hampton)

Jan 25 1922

UNDERTAKER

ADDRESS

Horace A. Burgee

363 Fells Rd

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

N 84 1922



D 60612

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60612

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *4*)

2-FULL NAME

(a) RESIDENCE

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If nonresident give city or town and State)

yrs

mos

ds

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed,

or Divorced (write the word)

*Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Mrs Sarah Thire*

6 DATE OF BIRTH (month, day, and year)

*Feb. 17, 1862*

7 AGE

Years

Months

Days

If LESS than  
1 day. hrs.  
or min.*59**11**7*

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

*Cook*9 BIRTHPLACE (city or town)  
(State or country)*Pa.*

10 NAME OF FATHER

*Jacob Thire*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Pa.*

12 MAIDEN NAME OF MOTHER

*Susan Miller*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Pa.*14 Informant  
(Address)*Mercy Hospital Record*

15

*Robert P. Harrison,*

Registrar

Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Jan 24 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan. 16 1922 to Jan. 24 1922*that I last saw him alive on *Jan. 24 1922*and that death occurred, on the date stated above, at *7:20 P. M.*

The CAUSE OF DEATH\* was as follows:

*Benign Prostatic  
hypertrophy*

CONTRIBUTORY

(Secondary)

18 Where was disease contracted

If not at place of death?

*Ch. Nephritis and**Home*

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

*Signs & symptoms,  
J. E. Harrison, M. D.  
Mercy Hospital*

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*York Pa.**Jan 24 1922*

20 UNDERTAKER

ADDRESS

*Wm. A. J. Francis & Son 708 N. Ave.*

CAUSE OF DEATH in plain terms, so that it may be understood by the coroner. See instructions on back of certificates. TION is very important.

AN 24 1922

## D 60613 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60613

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hosp.* ST. *13* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Albert M. Hare*

## (a) RESIDENCE. NO.

*1030 W. 38<sup>th</sup> St.* ST. *13* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *14* yrs. mos. ds.(If nonresident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male White*

## 4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *✓*

## 6 DATE OF BIRTH (month, day, and year)

*March 1, 1885*

## 7 AGE

*27*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Store Keeper*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Ind*

## 10 NAME OF FATHER

*George H Hare*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ind*

## 12 MAIDEN NAME OF MOTHER

*Maria Morrison*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ind*

## 14

Informant (Address)

*H. S. Hare  
1030 W. 38<sup>th</sup> St.*

## 15

*Robert P. Harrison,*

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 23* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *Jan 21*, 19 *22*, to *Jan 23*, 19 *22*that I last saw him alive on *Jan 23*, 19 *22*and that death occurred, on the date stated above, at *1:20 p. m.*

The CAUSE OF DEATH\* was as follows:

*Myocardial Insuff.*CONTRIBUTORY (Secondary) *Acute Hemorrhagic Pneumonia* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *1/23/22*

Was there an autopsy?

What test confirmed diagnosis? *S. W. K. M. D.* (Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Hampstead Ind Jan 26*

## 20 UNDERTAKER

*Chenoweth Son Chestnut*

Information should be carefully supplied so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

N 24 1922

D 60614 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

89 D 60614  
REGISTERED NO.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1354 Port ST., 6 WARD)

## 2. FULL NAME

(a) RESIDENCE NO. 1354 Port St. ST. 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary Myers

6 DATE OF BIRTH (month, day, and year) Aug-9-1858

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

AN 24 1922

Robert F. Harrison

19

Deputy Permit Clerk, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1922, to Jan 22, 1922,

that I last saw him alive on Jan 22, 1922,

and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH\* was as follows:

Coronary Atherosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Weller M. D.

Address 24 Bly

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Baltimore Cemetery 1/25 1922

UNDERTAKER

ADDRESS

John W. Moran, 24 Bly

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60615

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 1/2 Arlington ST., 16 WARD)

## 2-FULL NAME

Annie M. Sinclair

## (a) RESIDENCE NO.

825 1/2 N. Arlington ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Wm. S. Sinclair

6 DATE OF BIRTH (month, day, and year) aug- 1862

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

59 5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

H. W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany Youngham

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Donahue

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

W. S. Sinclair 825 1/2 N. Arlington ST.

Robert P. Harrison,

19

Permit Clerk Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 19 22

17 I HEREBY CERTIFY, That I attended deceased from Jan 16 1922 to Jan 22 1922 that I last saw her alive on Jan 22 1922 and that death occurred, on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 7

(duration) yrs. mos. ds. 1

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed)

Chas. H. Suber M. D.

(Address)

1100 W. Lafayette Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Loudan Park Cemetery 1/25 1922 J. A. Moran 3008 Balto

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

N 241922



D 60616

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60616

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 19

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St. 85 yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JAN 25 1922

ROBERT R. KRAUTER,

Burlat Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH,

1 24, 1922  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Jan 23, 1922 to Jan 24, 1922, that I saw her alive on Jan 24, 1922, and that death occurred, on the date stated above, at 10 40 a.m. The CAUSE OF DEATH\* was as follows:

Acute Peritonitis

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Intestinal Obstruction

(Signed) Mary F. Wagless, M.D.

Jan 24, 1922 (Address) 1028 Valley St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

D 60617

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60617

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1018 M. C.ulloh ST., 11 WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 1018 M. C.ulloh ST., 11 WARD

(Usual place of abode)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1/21/1922

7 AGE 56 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Common Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER NA

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Annie Turner 1018 M. C.ulloh

15 JAN 25 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23, 1922

17 I HEREBY CERTIFY That I attended deceased from April 1921, to Jan 23, 1922. That I last saw him alive on Jan 22, 1922, and that death occurred, on the date stated above, at 1:15 P. M.

The CAUSE OF DEATH\* was as follows:

Uremia (duration) yrs. 3 mos. 3 ds. CONTRIBUTORY Nephritis (duration) yrs. 10 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) John H. Thompson, M. D.

(Address) 1019 David Hill

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

ADDRESS

UNDERTAKER

David Easton

D 60618 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31-D 60618

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 1215 Ashland Ave

ST.: 10 WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Harry H. Kirby

## (a) RESIDENCE. NO.

1215 Ashland Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male.

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Jan 3 1877

## 7 AGE

45.

Years

Months

Days

If less than 1 day, hrs. or min.

20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(workman)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Lake City, S.C.

## 10 NAME OF FATHER

James H. Kirby

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Lake City S.C.

## 12 MAIDEN NAME OF MOTHER

Jennie A. Wood

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Charleston S.C.

## 14

Informant (Address)

one a Kirby 1215 Ashland Ave

## 15

Filed

JAN 25 1922

19

ROBERT H. SPALTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan 22 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

June 1920, to Jan 22, 1922, that I last saw him alive on Jan 22, 1922,

and that death occurred, on the date stated above, at 8:40 P. M.

The CAUSE OF DEATH\* was as follows:

Tuberculosis (Phtisis)

## CONTRIBUTORY (Secondary)

(duration) 3 yrs. - mos. ds. hemorrhage lung (bowels) (duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

don't know

Did an operation precede death? no Date of

Was there an autopsy?

(Laboratory)

What test confirmed diagnosis?

(Signed) Dr. A. C. Townsend, M. D.

, 19 (Address)

6 E. Preston

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION or REMOVAL

## DATE OF BURIAL

Oak Lawn Cemetery

May 25 1922

## 20 UNDERTAKER

## ADDRESS

Roth &amp; Turner

144 W. May

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates. TION is very important.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60619

D 60619

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1316 N. Broadway

CITY OF BALTIMORE: (No. 1316 N. Broadway ST. 8 WARD)

2-FULL NAME Mrs. Elise Gabriel

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 1316 N. Broadway ST. 8 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 MARRIED, WIDOWED, or DIVORCED (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Paul Gabriel

6 DATE OF BIRTH (month, day, and year) Dec. 12 1848

7 AGE Years 73 Months one Days 10 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

10 NAME OF FATHER Wilhelm Kroedel

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Elise Kroedel

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Paul Gabriel (husband) (Address) 1316 N. Broadway

15 JAN 25 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1921, to Jan. 22, 1922, that I last saw her alive on Jan. 22, 1922, and that death occurred, on the date stated above, at 8 p. m. The CAUSE OF DEATH\* was as follows:

Intestinal obstruction

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Carcinoma (duration) one yrs. mos. ds.

18 Where was disease contracted at place of death if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. D. Macdonald, M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL 1540 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS



**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Probably the Stomach  
first organ involved*

D 60620

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

201

D 60620

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Joseph Hospital* ST. WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *1243 Patterson Park Ave.* St. *10* yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE

MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE,  
(State or Country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER

(State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15

JAN 25 1922

ROBERT R. KRAUTER,

Filed

191

Burial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Rheumatism. Injured spine  
probably pushed cart.*

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *M. J. M. D.*(Address) *1524 19th St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the  
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60621  
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2000 West North St. 1st WARD)

2-FULL NAME Jacob Hechtel

(a) RESIDENCE NO. 2000 West North St. 1st WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 03 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE 5 Single Married Widowed, or divorced (in the word)

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-14-1850

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

JAN 25 1922

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-23-1922

17

I HEREBY CERTIFY That I attended deceased from

Jan 13, 1922, to Jan 23, 1922, that I last saw him alive on Jan 23, 1922, and that death occurred, on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH\* was as follows:

Hemiplegia, Cerebral Thrombosis &amp; Hemorrhage

CONTRIBUTORY (Secondary) Cerebral Thrombosis (duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frances A. Carpenter M. D.

Jan 24 1922 (Address) 2101 Madison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

20 UNDERTAKER

ADDRESS

William Cook

502 E North

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60622

## CERTIFICATE OF DEATH.

31 D 60622

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 821 W. Barre ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 821 W. Barre St.; 41 yrs., 11 mos., 11 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Jan 27, 1868  
(Month) (Day) (Year)

7-AGE,

53 yrs., 11 mos., 11 ds.  
If LESS than 1 day, ... hrs. or ... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work... Book Layer  
(b) General nature of industry, business, or establishment in which employed (or employer) 011

## 9-BIRTHPLACE

(State or Country) Baltimore Md.10-NAME OF FATHER, George H. Penn11-BIRTHPLACE OF FATHER (State or Country) Maryland12-MAIDEN NAME OF MOTHER Catherine Corsey13-BIRTHPLACE OF MOTHER (State or Country) Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hertle N. Penn(Address) 821 W. Barre

15-

Filed JAN 25 1922

ROBERT A. KRAUTER,

Bureau Permit Clerk Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan 23, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1922, to Jan 23 1922that I saw him alive on Jan 23 1922and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic Pulmonary  
Infection(Duration) 3 yrs., 11 mos., 11 ds.CONTRIBUTORY (Secondary) Chronic(Duration) 10 yrs., 11 mos., 11 ds.(Signed) L. M. Humphreys M. D.Jan 24, 1922 (Address) 821 W. Barre

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 11 yrs., 11 mos., 11 ds. In the State 11 yrs., 11 mos., 11 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Same19-PLACE OF BURIAL OR REMOVAL, ShadowDATE OF BURIAL, 1/26, 192220-UNDERTAKER McLaurin CorkADDRESS 502 E. North

CAUSE OF DEATH IN plain terms important. See instructions on back of certificate.



D 60623

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60623

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 Winchester ST. 16 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Eana Lorraine Thomas

## (a) RESIDENCE. NO.

1523 Winchester ST. 16 WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

11 mos.6 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE Negro 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 17<sup>th</sup> 19217 AGE Years Months Days If LESS than 1 day, hrs. or min. 11 6

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City, Maryland10 NAME OF FATHER James Owen Thomas11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland12 MAIDEN NAME OF MOTHER Lothie Skell13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.14 Informant Mrs. Lothie Thomas (Address) 1523 Winchester St.15 Filed JAN 25 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23<sup>rd</sup> 192217 I HEREBY CERTIFY, That I attended deceased from Jan. 14<sup>th</sup> 1922, to Jan. 23<sup>rd</sup> 1922, that I last saw h. w. alive on Jan. 22<sup>nd</sup> 1922, and that death occurred, on the date stated above, at 4:55 P. m.

The CAUSE OF DEATH was as follows:

Bronche pneumonia(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Phys. Signs Gas. Edw. Bell M. D.19 (Address) 1224 Gilmer St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Edw. Ruggold 1463 Perry

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
**CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Branchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
 BY PHYSICIAN.

*No infection prior*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60624

## CERTIFICATE OF DEATH.

90 D 60624

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 6 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Nathan Paris

## (a) RESIDENCE NO.

2577 Broadway ST.,

## WARD

(Usual place of abode)

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds.How long in U. S., if of foreign birth? Life yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced. (Write the word)

Child5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

— 1915

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.7

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

School9 BIRTHPLACE (city or town)  
(State or country)Baltimore

## 10 NAME OF FATHER

Nathan Paris11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Russia

## 12 MAIDEN NAME OF MOTHER

Ellie Gumbo13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Russia

## 14

Informant  
(Address)Nathan Paris  
2577 Broadway

## 15

JAN 25 1922

ROBERT N. MASTER,  
Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan 24 1922

## 17

I HEREBY CERTIFY, That I attended deceased from  
Jan 17 1922 to Jan 24 1922,  
that I last saw him alive on Jan 24 1922  
and that death occurred, on the date stated above, at 3:25 P.m.

## The CAUSE OF DEATH\* was as follows:

Chr. Valvular disease  
with myocardial  
decompensation(duration) yrs. 6 mos. ds.CONTRIBUTORY Myocardial decompensation  
(Secondary)(duration) yrs. 1 mos. ds.18 Where was disease contracted  
if not at place of death?at homeDid an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? Course of disease(Signed) Dr. Zimberg M. D.1/24, 1922 (Address) Hebrew Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Hebrew Hospital

## DATE OF BURIAL

1-25 1922

## 20 UNDERTAKER

## ADDRESS

Jack Reuts, 1411 E. 1st

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

D 60625

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 60625

## CERTIFICATE OF DEATH.

31

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 165 W. Henrietta ST. 73 WARD)

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD.

(If nonresident give city, town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18947 AGE Years Months Days If LESS than 1 day, hrs. or min. 27

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto10 NAME OF FATHER John Henry11 BIRTHPLACE OF FATHER (city or town) (State or country) md12 MAIDEN NAME OF MOTHER Ida Riley13 BIRTHPLACE OF MOTHER (city or town) (State or country) md14 Informant Ida Henry  
(Address) 165 W. Henrietta St.15 JAN 25 1922 ROBERT R. KRAUTER,  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 192217 I HEREBY CERTIFY, That I attended deceased from Nov 23, 1921 to Jan 23, 1922.that I last saw him alive on Jan 22, 1922.and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:

Tubercular brainCONTRIBUTORY  
(Secondary)18 Where was disease contracted if not at place of death? NoneDid an operation precede death? NO Date of —Was there an autopsy? NOWhat test confirmed diagnosis? Charcot's diagnosis(Signed) A. N. H. H. H. M. D.Address 712 8th Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Auburn Jan 25 192220 UNDERTAKER ADDRESS 142John H. Treadwell W. H. Treadwell

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.



D 60626

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60626

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 907 N. Fulton Ave. ST. 16 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mrs. Elizabeth Mildred Norman

## (a) RESIDENCE. NO.

907 N. Fulton Ave. ST. 16 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

W.

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John A. Norman

## 6 DATE OF BIRTH (month, day, and year)

Jan 6, 1886

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

66-18

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Franklin Va

## 10 NAME OF FATHER

Hintchenhoff

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Franklin Va

## 12 MAIDEN NAME OF MOTHER

Mildred Hoff

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Franklin Va

## 14

Informant (Address)

E. H. Norman 907 N. Fulton Ave.

## 15

JAN 25 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan 24 1922

## 17

I HEREBY CERTIFY, That I attended deceased from Jan 5, 1922, to Jan 24, 1922, that I last saw her alive on Jan 24, 1922, and that death occurred, on the date stated above, at 3 p. m. The CAUSE OF DEATH\* was as follows:

Chronic nephritis(duration) 3 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted If not at place of death?

## Did an operation precede death?

Date of

## Was there an autopsy?

## What test confirmed diagnosis?

Urinal - B.P. - symptoms

## (Signed)

Anna C. Todd M. D.

## 1/24 1922 (Address)

735 N. Fulton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Woodlawn CemJan 25 1922

## 20 UNDERTAKER

## ADDRESS

Arthur M. Gore1123 N. Fulton Ave

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60627

## CERTIFICATE OF DEATH

31 ✓ D 60627

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 631 N. Belnord Ave. ST.:

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Marguerita Seidenzall

## (a) RESIDENCE. No.

631 N. Belnord Ave.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 55 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Widow

## 5a If married, widowed, or divorced

(or) WIFE of

late Henry Seidenzall

## 6 DATE OF BIRTH (month, day, and year)

Mar 18 - 61

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.60105

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at Home

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Germany

## 10 NAME OF FATHER

John Franke

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

## 14

Informant (Address)

Frank H. Borchers  
631 N. Belnord Ave.

## 15

JAN 25 1922

ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan 23 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Sept, 1921, to Jan 23, 1922.that I last saw her alive on Jan 23, 1922.and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis(duration) yrs. 5 mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo A. Dwyer, M. D., 19 (Address) 2818 E. Baltimore St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Oak LawnJan 26 1922

## 20 UNDERTAKER

Philip Herwig

## ADDRESS

2016  
Avenue

D 60628

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 D 60628

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 S. Schroeder

ST.: 18 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo A. Doyle,

(a) RESIDENCE. No. 19 S. Schroeder

ST..

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 28 1890

7 AGE Years 31 Months 26 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmiths Helper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

10 NAME OF FATHER Wm. J. Doyle,

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md. (State or country)

12 MAIDEN NAME OF MOTHER Annie M. Fagen,

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md. (State or country)

14 Informant John Doyle, (Address) 1001 Hollins St.

15 Filed JAN 25 1922 J. E. McMan Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to Jan 23, 1922

that I last saw him alive on Jan 22, 1922

and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis (duration) 1 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? France 1914

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) J. T. McMan, M. D.

Address 2802 Edmondson Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL Jan. 25 1922

20 UNDERTAKER Geo W Little Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60629

## CERTIFICATE OF DEATH.

H4 D 60629

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 821 E. Chase ST. 10 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Timothy Sullivan

(a) RESIDENCE. NO. 821 E. Chase ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? 71 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary Sullivan

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

72

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

Daniel Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mellie Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14 Informant (Address) Mellie Sullivan 821 E. Chase St

15 Filed JAN 23 1922 H. W. Ehm Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1922

17 HEREBY CERTIFY, That I attended deceased from Jan 17, 1922, to Jan 24, 1922,

that I last saw him alive on Jan 24, 1922,

and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of Jan 18, 1922

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. C. Ponte, Jr., M. D.

19 (Address) St. Joseph's Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral

Jan 28 1922

20 UNDERTAKER

H. C. Wiedefeld 914 Greenmount

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.



D 60630

## HEALTH DEPARTMENT—CITY OF BALTIMORE

60630

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *18* ST.: *18* WARD)

## 2-FULL NAME

(a) RESIDENCE. No. *839, Raborg* ST.: *18* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *19* yrs. mos. *19* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Col.* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Single*6 DATE OF BIRTH (month, day, and year) *Apr. 23, 1883*7 AGE Years *38* Months *9* Days *-* If LESS than 1 day, hrs. *-* or min. *-*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *maid*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Phila. Pa.* (State or country)10 NAME OF FATHER *Robert Beck.*11 BIRTHPLACE OF FATHER (city or town) *Pa.* (State or country)12 MAIDEN NAME OF MOTHER *Mary Wright*13 BIRTHPLACE OF MOTHER (city or town) *Pa.* (State or country)14 Informant (Address) *11022 Hospital Road*15 Filed *Jan 19* Registrar *J. E. Weber*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 23, 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan 16, 1922* to *Jan 23, 1922* that I last saw her alive on *Jan 23, 1922* and that death occurred, on the date stated above, at *4:15 p.m.*

The CAUSE OF DEATH was as follows:

*Cardiac Decompen-*  
*sation*

CONTRIBUTORY (Secondary)

18 Where was disease contracted If not at place of death? *Home*Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *Signs of symptoms*(Signed) *John Brown M. D.*19 (Address) *11022 Hospital Road*

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cmt Auburn, Jan 25, 1922*

20 UNDERTAKER

ADDRESS *114**Brown & Leland, A. Schuch*

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates. TION is very important.

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Myocarditis and  
valvular lesion.  
Chronic*

D 60631

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 D 60631

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1108 N Freemont St.

WARD 16

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1108 N Freemont St.)

St. yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE

White

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

## 6-DATE OF BIRTH

May 25, 1853

## 7-AGE

69 yrs. 7 mos. 29 ds.

If LESS than 1 day.  
...hrs. or ...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

## 9-BIRTHPLACE, (State or Country).

Baltimore City, Md.

## 10-NAME OF FATHER

William A. Petzer

## 11-BIRTHPLACE OF FATHER (State or Country).

Balt. Md.

## 12-MAIDEN NAME OF MOTHER

Elizabeth P. Harris

## 13-BIRTHPLACE OF MOTHER (State or Country).

Balt. Md.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Thomas Dougherty

## 15-

Filed... 191... J. E. Wehm Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

Jan 25, 1922

17- I HEREBY CERTIFY, That I attended deceased from Dec 18, 1921, to Jan 23, 1922, that I saw her alive on Jan 23, 1922, and that death occurred, on the date stated above, at 6:30 P. M. The CAUSE OF DEATH\* was as follows:

Cardiac Dilatation from Chronic Valvular disease of the heart.

## CONTRIBUTORY (Secondary)

Arteriosclerosis of the heart (Duration) 15 yrs. or more.

(Signed)

Jan 23, 1922 (Address) 3583 N. Calvert

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Western Cemetery

Jan 26, 1922

## 20-UNDERTAKER

## ADDRESS

Frank Super 1400 N. North Ave.

CAUSE OF DEATH important. See instructions on back of certificate.

D 60632

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60632

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 20 mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

7-AGE

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JAN 25 1922

ROBERT R. KRAUTER

Registrar.

Burial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry) find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Inst. D.

(Address) 24 1st St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the  
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.



D 60633

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60633

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1739 N. Milton Ave. 8

WARD)

## 2-FULL NAME

Charles W. Jones

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1739 N. Milton Ave. ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 3 mos.

How long in U. S., if of foreign birth? 1 yr. 1 mos. 1 ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of Mrs. Ida F. Jones

(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Oct. 23<sup>rd</sup> 1877

## 7 AGE

Years

Months

Days

44

3

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Shipping clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Balto. Md

## 10 NAME OF FATHER

William P. Jones

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Md

## 12 MAIDEN NAME OF MOTHER

Mary Lynch

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Md

## 14

Informant (Address)

Mrs. Ida F. Jones 1739 N. Milton Ave.

## 15

Filed

JAN 25 1922

ROBERT H. KRAUTER, Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23<sup>rd</sup> 192217 I HEREBY CERTIFY, That I attended deceased from Jan. 17<sup>th</sup>, 1922, to Jan. 23<sup>rd</sup>, 1922.that I last saw him alive on Jan. 23<sup>rd</sup>, 1922.

and that death occurred, on the date stated above, at 1:40 a. m.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. 6 mos. 6 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinal chemical test

(Signed) A. W. Macdonald, M. D.

(Address) 1540 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

Baltimore Cemetery Jan. 26 1922

20 UNDERTAKER Serry Hovey, Sen 1301 E. Eager

D 60634

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60634

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1645 Clifton* ST., *8* WARD)2. FULL NAME *Charles B. Mett*(a) RESIDENCE NO. *1645 Clifton* ST., *8* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *46* yrs. *11* mos. *11* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb 13 1875*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*46**11**11*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Dispatcher for 080*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Stewart & Co.*

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Md*

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER *Edith J. Summerson*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Info

(A. Mrs. *M. Harry Mett*)

15

Info

(A. Mrs. *M. Harry Mett*)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 24 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Jan 6 1922* to *Jan 24 1922*.that I last saw him alive on *Jan 23 1922*and that death occurred, on the date stated above, at *3:45 P* m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis*(duration) *don't know* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address) *2708 Harford St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

JAN 25 1922

ROBERT R. KRAUTER,  
Burial Permit Clerk*Greenmount Cemetery*  
*Henry Horst Son**Jan 26 1922*  
*1301 E Eager St*

Information should be carefully checked, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 60635

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 D 60635

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *2132 E. Federal* ST., *8* WARD)

## 2. FULL NAME

*Constantine Jockisch*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *2132 E. Federal* ST., \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *40* yrs. — mos. — ds. How long in U. S., if of foreign birth? *40* yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of *Mr. Mary L. Jockisch* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *May 20 1883*  
7 AGE Years *68* Months *8* Days *x* If LESS than 1 day, .... hrs. or .... min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired Farmer*  
(b) General nature of industry, business, or establishment in which employed (or employer) *088*  
(c) Name of employer9 BIRTHPLACE (city or town) *Germany* (State or country)10 NAME OF FATHER *Joseph Jockisch*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Not Known*13 BIRTHPLACE OF MOTHER (city or town) *Not Known* (State or country)14 Informant *Mr. Mary L. Jockisch* (Address) *2132 E. Federal*

JAN 25 1922

ROBERT A. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 24 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan 18*, 1922, to *Jan 24*, 1922, that I last saw him alive on *Jan 23*, 1922, and that death occurred, on the date stated above, at *10:15 a.m.*

The CAUSE OF DEATH\* was as follows:

*Myocarditis*(duration) \_\_\_\_\_ yrs. *Two* mos. — ds.CONTRIBUTORY (Secondary) *Multiple neuritis*(duration) *10* yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of \_\_\_\_\_Was there an autopsy? *no*What test confirmed diagnosis? *Clinical symptoms*  
(Signed) *Wm. P. ...* M. D.*Jan 24, 1922* (Address) *17 E. Preston St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

*Holy Redeemer Cemetery* *Jan 27 1922*

20 UNDERTAKER

ADDRESS

*Henry Hoek Sen* *1501 E. Eager*

Information should be given in plain terms, so that it may be properly understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

DQ 60636

## HEALTH DEPARTMENT—CITY OF BALTIMORE

DQ 60636

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 Poplar Grove St. ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella May Travers

(a) RESIDENCE. No 1717 Poplar Grove St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Herman R. Travers

6 DATE OF BIRTH (month, day, and year) Sept. 13 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	4	6	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.  
(State or country)

10 NAME OF FATHER Matthew Gormley

11 BIRTHPLACE OF FATHER (city or town) Jersey City  
(State or country)

12 MAIDEN NAME OF MOTHER Rachael Shipley

13 BIRTHPLACE OF MOTHER (city or town) Howard Co. Md.  
(State or country)14 Informant Mr. Herman R. Travers  
(Address) 1717 Poplar Grove St.

15 Robert P. Harrison,

Burial Permit Clerk.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 24 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 1 1921 to Jan 24 1922  
that I last saw her alive on Jan 23 1922.

and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH\* was as follows:

Nephritis - Myocarditis

CONTRIBUTORY (Secondary) Edema of Lungs  
(duration) 1 yr. mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs  
(Signed) R. C. Metzger, M. D.

1/25 1922 (Address) 1903 W. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Pk. Cemetery

Ja. 26 1922

20 UNDERTAKER

ADDRESS

J. F. M. Cully

130 E. Fort

CAUSE OF DEATH in plain terms, so that it can be understood by laymen. See instructions on back of certificates.

N 85 1922



60637

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 D 60637

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 137 N Bradford ST., 6 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME Mary Tuve.

(a) RESIDENCE NO. 137 N Bradford ST., 6 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas Tuve.

6 DATE OF BIRTH (month, day, and year) March 7 1864

7 AGE Years 57 Months 10 Days 6. If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home 137

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Fleischman

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Fox Hoff.

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Anna Sutton (Address) 137 N Bradford

15 Robert P. Harrison Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24th 1922

17 I HEREBY CERTIFY, that I attended deceased from Jan 5th 1922 to Jan 24th 1922, that I last saw her alive on Jan 20th 1922, and that death occurred, on the date stated above, at 7:45 a.m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis (Pulmonary)

10 on 12 months

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? do not know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum examined

(Signed) R. P. Harrison M. D.

(Address) 137 N Bradford

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

Immortal Cem Jan 26 1922

20 UNDERTAKER

ADDRESS

A. Freeman 32 O'Donnell

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

N 25-1922

Burial Permit Clerk

D 60638

## HEALTH DEPARTMENT—CITY OF BALTIMORE

60638

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2130 N. Fulton ST., 15 WARD)

## 2. FULL NAME

Wm Chas Schmidtman

## (a) RESIDENCE NO.

(Usual place of abode) 2130 N. Fulton ST., 15 WARD  
Length of residence in city or town where death occurred 38 yrs. 8 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Susanna Schmidtman

6 DATE OF BIRTH (month, day, and year) May 4, 1883

7 AGE Years 38 Months 8 Days 19 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Susanna Schmidtman 2130 N. Fulton St.

15 Robert J. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1922, to Jan 23, 1922, that I last saw him alive on Jan 23, 1922, and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary) (duration) yrs. mos. 5 ds. Exhaustion (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas H. B. Hubert, M. D.

(Address) 1100 W. Lafayette Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Western Cem

20 UNDERTAKER

Wm. Dickman &amp; Sons North St.

DATE OF BURIAL

Jan 26, 22

ADDRESS

mation should be carefully examined, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

N 25 1922

Burial Permit Clerk.

# D. 60639 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 36 Hooper St. Wt Washington ST., 101 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert W. Litchford(a) RESIDENCE NO. 36 Hooper St. Wt Washington ST., 101 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower

6a If married, widowed, or divorced

HUSBAND of

(WIFE of) Olive Stevens Litchford6 DATE OF BIRTH (month, day, and year) June 20, 18787 AGE Years 48 Months 7 Days - If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Orderly at Hopkins(b) General nature of industry, business, or establishment in which employed (or employer) Hospital

(c) Name of employer

9 BIRTHPLACE (city or town) Md. (State or country)10 NAME OF FATHER Lewis E. Litchford11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)12 MAIDEN NAME OF MOTHER Margaret E. Snyder13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)14 Informant Miss Mary L. Litchford (Address) 745 W. 34 St.15 Robert P. Harrison,

Filed

19

Registrar

N 25 1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 192217 I HEREBY CERTIFY, That I attended deceased from Jan 17 1922 to Jan 24 1922That I last saw him live on Jan 24 1922and that death occurred, on the date stated above, at 158 m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -Was there an autopsy? NoWhat test confirmed diagnosis? Physical Signs (Signed) R. B. Norment M. D.124, 1922 (Address) 3747 Chestnut St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Marys Cemetery Jan 27 1922

20 UNDERTAKER

ADDRESS

Will Cook 502 E. North Ave

D 60640

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60640

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal HospitalST.: 76 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Russell(a) RESIDENCE. No. UnknownST.: 76 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18647 AGE Years Months Days If LESS than 1 day, hrs. or min. 57 -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown  
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown  
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)14 Informant Hospital Records,  
(Address) Municipal Hospital.15 Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23 19 2217 I HEREBY CERTIFY. That I attended deceased from December 20, 1921 to January 23, 1922.that I last saw her alive on January 23, 1922.and that death occurred, on the date stated above, at 12:50 P.m.

The CAUSE OF DEATH\* was as follows:

Chronic myocarditis(duration) 1 yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 1/24/22Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeil M. D.1/24/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Landover Park Jan. 26 19 2220 UNDERTAKER William Cook 3026 North Ave

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

N25 1922



D 60641

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60641

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *706 S Regester* ST. *2* WARD)

## 2-FULL NAME

*Kunegunda Kudlak*

## (a) RESIDENCE. NO.

*706 S Regester* ST. *2* WARD.  
(Usual place of abode)  
Length of residence in city or town where death occurred *4* yrs. *1* mos. *6* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Dec 9 1917*  
7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*4* *1* *16*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country)10 NAME OF FATHER *Frank Kudlak*11 BIRTHPLACE OF FATHER (city or town) *Baltimore*  
(State or country)12 MAIDEN NAME OF MOTHER *Frances Regester*13 BIRTHPLACE OF MOTHER (city or town) *Poland*  
(State or country)14 Informant *Frank Kudlak*  
(Address) *706 S Regester*15 *Robert P. Harrison,* Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 25 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan 24 1922* to *Jan 25 1922*  
that I last saw *her* alive on *Jan 25 1922* at *9:30 A.M.*and that death occurred, on the date stated above, at  
The CAUSE OF DEATH\* was as follows:*Laryngeal Diphtheria*CONTRIBUTORY (Secondary) *Cordae Polypus* (duration) yrs. mos. ds. *4*

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *William J. Rosen* M. D.  
(Address) *801 N. Guilford*

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Holy Rosary Jan 26 1922*

20 UNDERTAKER

*John M. Weber 1803 Bank St.*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

AN 85 1922

D 60642

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 D 60642

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No.

3607 Forest Park Dr., 15

WARD)

## 2-FULL NAME

James J. Allen

(Residence in Baltimore: No.

3607 Forest Park Dr.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. (da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH,

Feb. 14, 1870

7-AGE,

51 yrs., 9 mos., 9 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).Manager  
Eng. Engineering

9-BIRTHPLACE,

(State or Country).

Canada

19-NAME OF FATHER,

Thos. Allen

11-BIRTHPLACE OF FATHER

(State or Country).

unknown

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER

(State or Country).

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Ella Crow Allen

(Address).

3607 Forest Park Dr.

15-

Robert P. Harrison,

Filed

191

Registrar.

Serial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH,

Jan. 23, 1922

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Myocardial disease

(Duration) 3 yrs., 9 mos., 9 ds.

CONTRIBUTORY no history

(Duration) 3 yrs., 9 mos., 9 ds.

(Signed) J. J. Harrison, M. D.

(Coroner.) Jan. 25, 1922 (Address) 2802 E. Lombard Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs., mos., ds. State yrs., mos., ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

London Park Cem.

DATE OF BURIAL,

Jan. 26, 1922

20-UNDERTAKER

Harry W. Chlen

ADDRESS 1944

W. North Ave.

B- Every item of information on this certificate is important. See instructions on back of certificate.

JAN 27 1922

# D 60643 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hotel Rennert ST.: 4 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Co. Md.

## 2-FULL NAME

JOHNZIE EDWARD BEASMAN

## (a) RESIDENCE. NO.

Hotel RennertST.: 4WARD. (Sykesville, Carroll)

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 25 ds. How long in U. S., if of foreign birth? 69 yrs. 10 mos. 9 ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Laura Bennett Beasman6 DATE OF BIRTH (month, day, and year) March-16-1852

## 7 AGE

Years

69

Months

10

Days

9If LESS than  
1 day. hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer and(b) General nature of industry, business, or establishment in which employed (or employer) Politician.

(c) Name of employer

(self)

## 9 BIRTHPLACE (city or town) (State or country)

Freedom, Carroll Co. Maryland10 NAME OF FATHER Joshua Beasman11 BIRTHPLACE OF FATHER (city or town) Freedom,  
(State or country) Carroll Co., Md.12 MAIDEN NAME OF MOTHER Narcissa Gore13 BIRTHPLACE OF MOTHER (city or town) Freedom,  
(State or country) Carroll Co., Md.

## 14

Informant Mrs. Laura B. Beasman, (wife)  
(Address) Hotel Rennert, City.

## 15

Filed Robert P. Harrison,  
R. Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 19 22

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan 17 19 22 to Jan 25 19 22  
that I last saw him alive on Jan 25 19 22and that death occurred, on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH\* was as follows:

Acute Myocarditis

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

Disease of fall Bladder

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

125 1922 Address 117 W. Saratoga St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

SYKESVILLE, CARROLL CO. Md. Jan-27-1922

## 20 UNDERTAKER

WILLIAM F. WOODEN, Successor

ADDRESS

103 W. NORTH AVE.

Information should be carefully supplied. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60644

## CERTIFICATE OF DEATH.

D 60644

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509 E Biddle ST., 8 WARD)

## 2-FULL NAME

Lula M. Parlett

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1509 E Biddle

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 9 mos. 25 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 30<sup>th</sup> 1876

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45925

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

School Teacher

## (b) General nature of industry, business, or establishment in which employed (or employer)

Balto City School

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

## 10 NAME OF FATHER

George M. Parlett

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Co Md

## 12 MAIDEN NAME OF MOTHER

Elizabeth Buckheimer

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

## 14

Informant (Address)

George M. Parlett  
303 E 33rd St

## 15

JAN 26 1922

ROBERT R. KRAUTER,  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24<sup>th</sup> 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan 15, 1922, to Jan 24, 1922,  
that I last saw her alive on Jan 24, 1922,and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage probably  
an embolus

(duration)

yrs.

mos. 12 mos.

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos. 3 ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt Davis, M. D.

, 19

(Address)

1509 E Caroline St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Green Ridge Cemetery

## DATE OF BURIAL

Jan 27<sup>th</sup> 1922

## 20 UNDERTAKER

George Schilling & Sons

## ADDRESS

1126 E Monument St

Information should be given in plain terms, so that it may be properly understood. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60645

## CERTIFICATE OF DEATH.

D 60645

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland General Hospital* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. *822 West Pratt* ST., *WARD.*(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred *10* yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 23, 1902*7 AGE Years *19* Months *6* Days *1* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer9 BIRTHPLACE (city or town) (State or country) *Elkton Virginia*10 NAME OF FATHER *J. B. Walton*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Virginia*12 MAIDEN NAME OF MOTHER *Bessie E. Riddle*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Virginia*14 Informant *Mrs Bessie E. Walton* (Address) *822 W. Pratt St*15 *JAN 26 1922* ROBERT R. KRAUTER, Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan. 24 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan 21, 1922*, to *Jan 24, 1922* that I last saw him alive on *Jan 24, 1922* and that death occurred, on the date stated above, at *7.05 P.m.*

The CAUSE OF DEATH\* was as follows:

*General peritonitis*CONTRIBUTORY (Secondary) *Cardiac Failure* (duration) yrs. mos. *8* ds.18 Where was disease contracted if not at place of death? *822 W. Pratt St*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *John W. Metcalf*, M. D.  
, 19 (Address) *M.D. General Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Woodlawn cemetery* DATE OF BURIAL *Jan 27 1922*20 UNDERTAKER *H. W. Rounton* ADDRESS *2238 W. North Ave*

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Impossible to get any  
other cause or history.  
Very sick when brought  
into hospital.*

*J. J. Hennessey  
Coroner N. W. Dix*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60646

## CERTIFICATE OF DEATH.

D 60646

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3819 Fernwood Ave 26* WARD)

## 2-FULL NAME

*Mary A Swisher*

## (a) RESIDENCE. NO.

*3819 Fernwood Ave 26 WARD.*

(Usual place of abode)

Length of residence in city or town where death occurred

*2* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Married*

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*James R Swisher*

## 6 DATE OF BIRTH (month, day, and year)

*July 25-1875*

## 7 AGE

*46*

Years

*5*

Months

*28*

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Chamberburg Pa*

## 10 NAME OF FATHER

*Adam Smith*

## 11 BIRTHPLACE OF FATHER (city or town)

*Chamberburg Pa*

## 12 MAIDEN NAME OF MOTHER

*Frances McGuiggan*

## 13 BIRTHPLACE OF MOTHER (city or town)

*Chamberburg Pa*

## 14

Informant  
(Address)*James R Swisher  
3819 Fernwood Ave*

## 15

*JAN 26 1922**ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 23 1922*

17 I HEREBY CERTIFY, That I attended deceased from

*January 11, 1922, to January 23, 1922,*that I last saw her alive on *January 23, 1922,*and that death occurred, on the date stated above, at *9 40 P* m.

The CAUSE OF DEATH\* was as follows:

*Acute Endocarditis*(duration) yrs. mos. *12* ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Geo. J. Lockbocker, M. D.*

, 19

(Address)

*808 S. Third St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Oak Lawn Cemetery Jan 26 1922*

## 20 UNDERTAKER

*John F. Denny*

## ADDRESS

*715 Light*

CAUSE OF DEATH in plain terms, so that it may be understood by the jury. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Acute articular rheumatism  
Phy had been treating her  
for about since last  
summer. No further  
history.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60647

## CERTIFICATE OF DEATH.

44 D 60647

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1928 E. Madison St. ST. 7 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Clause Brown

## (a) RESIDENCE NO.

1928 E. Madison St. ST. 7 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos.How long in U. S., if of foreign birth? 40 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Lena Brown

## 6 DATE OF BIRTH (month, day, and year)

1869

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

53——

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

Grocery

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Russia

## 10 NAME OF FATHER

Jacob Brown

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

## 12 MAIDEN NAME OF MOTHER

Zelds

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

## 14

Informant

(Address)

Jack Lewis1411 E. Baltimore St.

## 15

JAN 26 1922

ROBERT R. KRAUTER,

Burial Permit Clerk, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Jan 1, 19 22, to Jan 26, 19 22.that I last saw him alive on Jan 30, 19 22.and that death occurred, on the date stated above, at 29 m.

The CAUSE OF DEATH\* was as follows:

Coronary thrombosis(duration) 2 yrs. 2 mos. — ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death? 1928 E. Madison St.Did an operation precede death? yes Date of Jan 2/22Was there an autopsy? noWhat test confirmed diagnosis? Spectroscopy(Signed) Blanche P. Thomas M. D., 19 (Address) 302 E. Baltimore St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Hebrew Burying Ground1/26 1922

## 20 UNDERTAKER

## ADDRESS

Jack Lewis 1411 E. Baltimore St.

Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Esophageal end  
of stomach origin  
of cancer.*

D 60648

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

60648

## PLACE OF DEATH

CITY OF BALTIMORE (No. *179* ST. *179* WARD)

## FULL NAME

(Residence in Baltimore: No. *3817 Mt Pleasant* St.: yrs. *17* mos. *17* da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

Filed

JAN 26 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) And that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Burns Accidents  
Chloroform from stool  
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. H. Foster* M. D.  
(Coroner.)

1-25, 1912 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the  
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

*W. Lander Sons**1710 West St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60649

D 60649

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 N Broadway ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Farberman(a) RESIDENCE. NO. 13 N Broadway ST.: 6 WARD.(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred 16 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown7 AGE Years 86 Months — Days — If LESS than 1 day, hrs. — or min. —

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia10 NAME OF FATHER Ben Farberman11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia14 Informant Harris Farberman (Address) 2418 Calver Ave15 JAN 26 1922 ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/26<sup>th</sup> 192217 I HEREBY CERTIFY, That I attended deceased from Sept, 1921, to Jan 25<sup>th</sup>, 1922, that I last saw him alive on Jan 25<sup>th</sup>, 1922, and that death occurred, on the date stated above, at 6 a. m.  
The CAUSE OF DEATH\* was as follows:  
Chronic Interstitial Nephritis  
CONTRIBUTORY (Secondary) Dilatation of Heart  
(duration) yrs. mos. ds. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. J. Tarkenton M. D.19 Address 119 N. Milton

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Hebrew Mt Carmel Jan 26 1922  
ADDRESS 1127E

20 UNDERTAKER

Max Linsen Baltimore

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates. TION is very important.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant

(Address)

15

Filed

JAN 26 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

ST.: 5

WARD)

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Diarrhoea (not dysentery)

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Horace E. Stewart, M. D.

1/25, 1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 60651

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60651

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *14* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. *1516 Melrose St.* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *3* yrs. *3* mos. *3* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *—*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *—*6 DATE OF BIRTH (month, day, and year) *Oct 20 1918*7 AGE Years *3* Months *3* Days *5* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *—*(b) General nature of industry, business, or establishment in which employed (or employer) *—*(c) Name of employer *—*9 BIRTHPLACE (city or town) *Balto Md.* (State or country)10 NAME OF FATHER *Leo J. Klaus*11 BIRTHPLACE OF FATHER (city or town) *Md.* (State or country)12 MAIDEN NAME OF MOTHER *Madeline Miller*13 BIRTHPLACE OF MOTHER (city or town) *Md.* (State or country)14 Informant *Mercy Hospital* (Address) *Room 202*15 *GRADY G. NALL* ROBERT R. KRAUTER, Burial Permit Clerk.

JAN 26 1922

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 25 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan 24 1922* to *Jan 25 1922*, that I last saw him alive on *Jan 25 1922*, and that death occurred, on the date stated above, at *6 P. m.*

The CAUSE OF DEATH was as follows:

*Ruptured sigmoid colon  
spontaneous*

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *yes* Date of *Jan 24 1922*Was there an autopsy? *yes*What test confirmed diagnosis? *Autopsy*(Signed) *John J. Egan, M. D.*, 19 (Address) *Mercy Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Woodlawn*20 UNDERTAKER *Wm. Cook*

DATE OF BURIAL

*Jan 26 1922*

ADDRESS

*502 E. North*

CAUSE OF DEATH in plain terms, so that it may be read by laymen. See instructions on back of certificates.

D 60652

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

49 D 60652

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1143 N. Stricker ST. 16 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Richard Samuel Harrison

## (a) RESIDENCE. NO.

1143 Stricker

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

8 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced (write the word)

Male White married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Emma Harrison

## 6 DATE OF BIRTH (month, day, and year)

Unknown

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

58

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Supt. of Harb.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Md

## 10 NAME OF FATHER

Samuel Harrison

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Md

## 12 MAIDEN NAME OF MOTHER

Mary Hadaway

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md

## 14

Informant  
(Address)Emma Harrison  
1143 N. Stricker St.

## 15

JAN 26 1922

ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

January 24 1922

## 17

HEREBY CERTIFY, That I attended deceased from  
October 25, 1922, to January 24, 1922.

that I last saw him alive on

Jan. 23, 1922.

and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Prostate  
Gland & neck of urinary  
Bladder

(duration) — yrs. 2 mos. 27 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Cystoscopic examination

(Signed)

Charles E. Clark

M. D.

1-24-22 (Address)

1306 N. Gilman St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Cathedral Cem.

Jan 27 1922

## 20 UNDERTAKER

## ADDRESS

Martin Kucharsky 1824 W. North

D 60653

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101' D 60653

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No.

2130 McElderry

ST.:

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Walter Gibson

## (a) RESIDENCE. No.

2130 McElderry

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. — mos. — ds.

How long in U. S., if of foreign birth? yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male Col Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 18, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

22

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Auto mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md

## 10 NAME OF FATHER

Lewis Gibson

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Md

## 12 MAIDEN NAME OF MOTHER

Annelle Goates

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Md

## 14

Informant

William C. Gibson

(Address)

2130 McElderry St

## 15

JAN 26 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 18, 1922, to Jan. 23, 1922.

that I last saw him alive on Jan. 23, 1922.

and that death occurred, on the date stated above, at 4:50 p. m.

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia

(duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

Acute bronchitis

(duration) yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) W. C. Robinson M. D.

1922 Address 1520 E Monument St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Laurel Cemetery Jan 26 1922

20 UNDERTAKER

ADDRESS

James M. Skinner 1627 E Madison St



D 60654

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 790 W Mulberry ST. 17 WARD)

## 2-FULL NAME

(a) RESIDENCE. NO. 790 W Mulberry ST. 17 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds. How long in U. S., if of foreign birth?

(If nonresident give city or town and State)

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed,

or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15

JAN 26 1922

ROBERT A. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 23, 1922, to Jan 25, 1922,

that I last saw him alive on Jan 25, 1922,

and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Paralysis

(duration)

yrs.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1/26/1922 (Address) 1197 Carrollton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Auburn Cemetery

20 UNDERTAKER

John H. Hadwin 142 N. Hill St

CAUSE OF DEATH in plain terms, so that it may be properly  
TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Injuries at birth*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60655

## CERTIFICATE OF DEATH.

D 60655

## PLACE OF DEATH

CITY OF BALTIMORE (No. 1143 Woodyear

ST. 16 WARD)

REGISTERED NO. C

## 2-FULL NAME

Baby Daniel

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1143 Woodyear St.

St.: yrs. mos. 1 da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, Jan. 23, 1922 (Month) (Day) (Year)

7-AGE, If LESS than 1 day, 9 hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE. (State or Country).

## 10-NAME OF FATHER.

## 11-BIRTHPLACE OF FATHER (State or Country).

## 12-MAIDEN NAME OF MOTHER.

## 13-BIRTHPLACE OF MOTHER (State or Country).

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 23, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the removal described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Patent foramen ovale (Duration) yrs. mos. 1 da.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) J. E. T. Pennessy M. D. (Coroner.)

Jan. 25, 1922 (Address) 202 E. Calumet St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

## 20-UNDERTAKER

## ADDRESS

15-

JAN 26 1922

ROBERT R. KRAUTER,

Burial Permit Registrar.

JOHN HOPKINS HOSPITAL

Commissioner of Health,

DATE OF BURIAL,

JAN 25 1922

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60656 CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO

500 Number

ST. 17

WARD

## 2-FULL NAME

Baby Clark.

## (a) RESIDENCE. NO.

500 Number

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

Caucasian

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Jan-19-1922

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

## 10 NAME OF FATHER

Thomas Clark

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Canada

## 12 MAIDEN NAME OF MOTHER

Mary Jones

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Maryland

## 14

Informant (Address)

## 15

JAN 26 1922

ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan-22 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan-19-1922, to Jan-22, 1922,

that I last saw her alive on Jan-22, 1922,

and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH\* was as follows:

Prematurity.

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

Unknown.

(duration)

yrs.

mos.

ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed)

, 19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

HOPKINS HOSPITAL

19

## 20 UNDERTAKER

## ADDRESS

Commissioner Health.

JAN 25 1922



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60657

## CERTIFICATE OF DEATH.

31 D 60657

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 S. Calhoun ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 231 S. Calhoun St.; 51 yrs.,  mos.,  ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Male

## 4-COLOR OR RACE

White5-STATUS,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)  
married

## 6-DATE OF BIRTH

Mar 7, 1870  
(Month) (Day) (Year)

## 7-AGE

51 yrs.,  mos.,  ds.If LESS than 1 day,  
....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).Clerk9-BIRTHPLACE,  
(State or Country),Baltimore

## 10-NAME OF FATHER,

George Deems11-BIRTHPLACE OF FATHER  
(State or Country),Baltimore

## 12-MAIDEN NAME OF MOTHER

Mary A Ritter13-BIRTHPLACE OF MOTHER  
(State or Country),Baltimore

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lillian A. Deems

(Address)

231 S. Calhoun St.

## 15-

JAN 26 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan 22, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Nov 2 1921, to Jan 22 1922, that I saw him alive on January 22 1922, and that death occurred, on the date stated above, at 11 P. m. The CAUSE OF DEATH\* was as follows:Pulmonary Hemorrhage  
(Duration) Half hourCONTRIBUTORY  
(Secondary)Diabetes Mellitus & Pulmonary Interstitial  
(Duration) 10 yrs. 10 mos., 10 ds.

(Signed)

John W. Fayette M. D.  
Jan 22, 1922 (Address) 1203 W. Fayette St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death  yrs.,  mos.,  ds. In the  yrs.,  mos.,  ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

London Park Cem

## DATE OF BURIAL,

1-26, 1922

## 20-UNDERTAKER

Robert Brook & Son

## ADDRESS

Calhoun St

CAUSE OF DEATH in plain terms, if any, on back of certificate. important. See instructions on back of certificate.

D 60658

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60658

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 Battery Ave.

ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gladys M. Moore

(a) RESIDENCE. NO. 1114 Battery Ave.  
(Usual place of abode)

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 12 1905

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
16 11 13

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.  
(State or country)

10 NAME OF FATHER John M. Moore

11 BIRTHPLACE OF FATHER (city or town) Md.  
(State or country)

12 MAIDEN NAME OF MOTHER Josephine E. Carter

13 BIRTHPLACE OF MOTHER (city or town) Md.  
(State or country)14 Informant Mr. Henry Dougherty  
(Address) 1114 Battery Ave.15 JAN 26 1922 ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1922, to Jan 25, 1922, that I last saw her alive on Jan 24, 1922, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH\* was as follows:

Acute cardiac dilatation

CONTRIBUTORY (Secondary)

18 Where was disease contracted  
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinal

(Signed)

(Address)

\*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Cemetery

Jan. 27 1922

20 UNDERTAKER

ADDRESS

J. Faw M. Cully 130 E. Fort

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

D 60659 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60659

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2105 Hollins

ST.: 20 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Alice Colley

## (a) RESIDENCE. NO.

2105 Hollins

ST.: 20 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Nov 20-1859

## 7 AGE

Years 62

Months 2

Days 3

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

## 10 NAME OF FATHER William Henry Colley

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md

## 12 MAIDEN NAME OF MOTHER Elizabeth Hesser

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Howard Co. Md

## 14

Informant

Mrs Nellie Speake

(Address)

2105 Hollins St

## 15

JAN 26 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 8- 1921, to Jan 22, 1922.

that I last saw her alive on Jan 22, 1922.

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma Stomach

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

E. Heller Hesser, M. D.

1/26/1922 (Address)

2000 Hollins St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Western Cemetery Jan 26 1922

## 20 UNDERTAKER

## ADDRESS

George L. Schmal 2101 E. Hollins St

D 60660

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60660

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1114 S. Carey*)ST. *21*

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. *1114 S. Carey*

(Usual place of abode)

Length of residence in city or town where death occurred *67* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Wds.* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*6 If married, widowed, or divorced, HUSBAND of (or) WIFE of *William H. Bell*6 DATE OF BIRTH (month, day, and year) *Mar. 22 - 1854*7 AGE Years *67* Months *2* Days *1* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*(b) General nature of industry, business, or establishment in which employed (or employer) *at home*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Massachusetts*10 NAME OF FATHER *Mr. Townsend*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ind.*12 MAIDEN NAME OF MOTHER *Burns*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ind.*14 Informant *Miss Bell* (Address) *1114 S. Carey St.*15 File *26* JAN 26 1922Registrar *George L. Schwalbe*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 23* 192*2*17 I HEREBY CERTIFY, That I attended deceased from *Jan 11*, 19*22*, to *Jan 23*, 19*22*.that I last saw him alive on *Jan 22*, 19*22*.and that death occurred, on the date stated above, at *7:20 a. m.*

The CAUSE OF DEATH was as follows:

*Pharyngeal cancer  
High Blood pressure*CONTRIBUTORY (Secondary) *7* yrs. mos. ds.(duration) *7* yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? *no* Date of —Was there an autopsy? *no*What test confirmed diagnosis? *urinalysis*(Signed) *Stanley Pearson* M. D.Jan 24, 1922 (Address) *1114 S. Carey St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *London Park*DATE OF BURIAL *Jan 26* 19*22*20 UNDERTAKER *George L. Schwalbe*ADDRESS *1114 S. Carey St.*



D 60661 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE, NO. 1913 E Chase ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE, NO. 1913 E Chase ST., 7 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of

(Name) Elizabeth Smith

6 DATE OF BIRTH (month, day, and year) July 16 - 1837

7 AGE Years 84 Months 6 Days 8 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

Filed

JAN 26 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1922

17 I HEREBY CERTIFY, that I attended deceased from

Oct 25 - 1921, to Jan 24, 1922

that I last saw him alive on Jan 24, 1922

and that death occurred, on the date stated above, at 3 40 P. m.

The CAUSE OF DEATH\* was as follows:

Cardiac Asthenia

(duration) yrs. mos. ds. 10

Myocarditis, Nephritis,

Secondary (duration) yrs. mos. ds. 3

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) Abner B. Luman, M. D.

1203 718 21 Pat P. K. an

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Cemetery Jan 27 1922

20 UNDERTAKER ADDRESS 1203

Henry Lutz W. Broadway

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60662

## CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

Franklin Sq. Hosp.

ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No.

2-FULL NAME

Miss Mary E. Murray

St.; 44 yrs. 84 ds.)

(Residence in Baltimore: No.

805 Light St

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

January 1, 1876

7-AGE

44 yrs. 0 mos. 24 ds.

If LESS than 1 day, 12 hrs. 0 min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).Clerical  
Merchant

9-BIRTHPLACE, (State or Country).

Baltimore

10-NAME OF FATHER,

P. J. Murray

11-BIRTHPLACE OF FATHER (State or Country).

Ireland

12-MAIDEN NAME OF MOTHER

M. Flannigan

13-BIRTHPLACE OF MOTHER (State or Country).

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

H. J. Parr

(Address)

Franklin Sq. Hosp.

15-

JAN 26 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan

25, 1922

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

Jan 24 1922, to Jan 25 1922

that I saw him alive on Jan 24 1922

and that death occurred, on the date stated above, at 4:45 am

The CAUSE OF DEATH\* was as follows:

Strangulated Hernia with Intestinal Obstruction

(Duration) yrs. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 4 mos. 4 ds.

(Signed)

H. J. Parr

M. D.

(Address)

Franklin Sq. Hosp.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT OR RECENT RESIDENTS)

At place of death 12 hrs. In the State 44 yrs. 84 ds.

Where was disease contracted, if not at place of death?

Home

Former or usual residence

805 Light St

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral Cem.

DATE OF BURIAL,

Jan. 28, 1922

ADDRESS

20-UNDERTAKER

F. A. Trauer &amp; Son

7039 Hanover St

CAUSE OF DEATH in your certificate. See instructions on back of certificate. important.

D 60663

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60663

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1707 E. Lanvale*ST.: *8* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Catherine Kern*(a) RESIDENCE. NO. *1707 E. Lanvale*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *70* yrs. mos.ds. How long in U. S., if of foreign birth? *70* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*white*

5 Single, Married, Widowed, or Divorced (write the word)

*widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*John Kern*

6 DATE OF BIRTH (month, day, and year)

*July 6 1837*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*84**11**19*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Germany*

10 NAME OF FATHER

*Reichert*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Germany*

14

Informant

(Address)

*Miss Gayle Kern  
1707 E. Lanvale*

15

JAN 26 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Jan 25 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*July 1 1922, to Jan 24 1922,*that I last saw him alive on *Jan 24 1922,*and that death occurred, on the date stated above, at *9-45 A m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Intestinal Apathy*(duration) yrs. *6* mos. ds.CONTRIBUTORY *Endocarditis*

(Secondary)

(duration) yrs. *3* mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *urine*(Signed) *John T. Carey* M. D., 19 (Address) *1603 N. Broadway*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

*5th German Reformed Congregation Jan 27 1922*

20 UNDERTAKER

ADDRESS

*Chas. G. Black 742 W North Ave*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60664

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 N. Bantam WARD) 162-FULL NAME William N. Horstkamp(a) RESIDENCE. No. 627 N. Bantam St. WARD. 16  
(Usual place of abode) (If nonresident give city or town and State)Length of residence in city or town where death occurred 54 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 ~~Single~~ Married, Widowed, or Divorced (write the word) Widower5a If married, widowed, or divorced:  
HUSBAND of Marion C. Horstkamp  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Nov 10 18427 AGE Years 79 Months 2 Days 15 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D. C.10 NAME OF FATHER Mr. Horstkamp11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Not Known13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany14 Informant Flora Guyenall  
(Address) 627 N. Bantam15 JAN 26 1922 ROBERT R. KRAUTER,  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 19 2217 I HEREBY CERTIFY, That I attended deceased from Dec 22, 19 22 to Jan 25, 19 22, that I last saw him alive on Jan 25/22, 19 22.And that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH\* was as follows:

Bronchial Pneumonia(duration) yrs. mos. 7 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? yes(Signed) J. A. Byatt M. D., 19 (Address) 351 7th St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Washington, D. C. Jan 27 19 22

20 UNDERTAKER ADDRESS

for friends Son 217 J. P. Ave



D 60665

Spec. 6-2-19-H. P. Co.-1000 Bks.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60665

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 827 S Kenwood ST. 1 WARD)

## 2-FULL NAME

(a) RESIDENCE. NO. 827 S Kenwood ST. 1 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. - mos. - ds.How long in U. S., if of foreign birth? - yrs. - mos. - ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-1-21

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Arty Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Stan. Novacka

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address) 827 S Kenwood Ave

15

Robert F. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 192217 I HEREBY CERTIFY, That I attended deceased from Jan 24 1922, to Jan 25 1922, that I last saw him alive on Jan 25 1922, and that death occurred, on the date stated above, at 4:18 m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 3

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at homeDid an operation precede death? No Date of -Was there an autopsy? NoWhat test confirmed diagnosis? Physical signs(Signed) C. S. Miller(Address) 1408 S. Park

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Stanislaus Cemetery Jan 27 1922

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

N 26 1922

D 60666 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 60666

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.: *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 24, 1922, to Jan 25, 1922*that I last saw him alive on *Jan 25, 1922*and that death occurred, on the date stated above, at *5:50 P.M.*

The CAUSE OF DEATH\* was as follows:

*Foreign body in Lung.*

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

AN 261922

Hagerstown Md  
W. W. Thriver*Jan. 27 1922**1018**Edmondson*

mation should be carefully supplied. See instructions on back of certificates.

D 60667 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 60667

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2120 N. Charles St. 12 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2120 N. Charles St.)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. / ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male  
4-COLOR OR RACE, white  
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, widowed (Write the word.)  
6-DATE OF BIRTH, Sept 17, 1869 (Month) (Day) (Year)  
7-AGE, 62 yrs., 11 mos., 7 ds. If LESS than 1 day, ...hrs. or...min.  
8-OCCUPATION: (a) Trade, profession, or particular kind of work, Manager in office  
(b) General nature of industry, business, or establishment in which employed (or employer), Gents. Tailoring & Hatting in West Md.

9-BIRTHPLACE, (State or Country), Baltimore Co Md.

10-NAME OF FATHER, John H Beckley

11-BIRTHPLACE OF FATHER (State or Country), Baltimore City

12-MAIDEN NAME OF MOTHER, Catherine Alder

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. George Johnson  
(Address) #2120 N. Charles St.

15-

Robert P. Harrison, Registrar.

Patrol Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 24, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Coronary Artery Disease  
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.  
(Signed) John P. Harrison, M. D. (Coroner)  
(Address) 3632 Rutland

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence, Whitching W. Va.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Southern Cemetery Jan 27, 1922

20-UNDERTAKER, R. E. Edson, ADDRESS, Rutland

D 60668

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60668

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 N. Bruce St.

ST. 19 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME **Jessie Edward Powell Jr.**(a) RESIDENCE NO. 507 N. Bruce St.  
(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male Negro Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/2./'20

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
20 10 22

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Muscian

(b) General nature of industry, business, or establishment in which employed (or employer) Played drums in Movie House

(c) Name of employer Frank F. Horning  
Baltimore

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER **Jessie Edward Powell Sr.**

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md. Co. Unknown

12 MAIDEN NAME OF MOTHER Rebecca Hawkins

13 BIRTHPLACE OF MOTHER (city or town) Relay

(State or country) Md. Baltimore Co.

14 Informant Rebecca Edwards (Mother)

(Address) 507 N. Bruce

15 Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18th 1922, to Jan. 24th. 1922.

that I last saw him alive on Jan. 21. 1922, 5 a. m.

The CAUSE OF DEATH\* was as follows:

Anemia, Pernicious

About (duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

No.

Was there an autopsy?

What test confirmed diagnosis? Blood test

(Signed) Walter J. Jackson M. D.

19 (Address) 1618 W. Mulberry St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL DATE OF BURIAL

Crodensville Cemetery Jan 27 1922

20 UNDERTAKER

Daniel Taylor

ADDRESS

Ba ar

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

N 261922

Burial Permit Clerk.



153303  
D 60669

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 60669

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL.

ST.

WARD) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Geraldine Dall

## (a) RESIDENCE. NO.

1623 McCallah

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

July 20 - 1921

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

## 10 NAME OF FATHER

John Dall

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

## 12 MAIDEN NAME OF MOTHER

Selma Lee

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

## 14

Informant (Address)

JOHNS HOPKINS HOSPITAL.

## 15

Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan 26 - 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan 9 - 1922, to Jan 26 - 1922,

that I last saw him alive on Jan 26 - 1922,

and that death occurred, on the date stated above, at 3:45 P.M.

The CAUSE OF DEATH\* was as follows:

Retropharyngeal abscess

(duration) yrs. mos. 17 ds.

## CONTRIBUTORY (Secondary)

Streptococcus meningitis

(duration) yrs. mos. 21 ds.

## 18 Where was disease contracted

If not at place of death?

Home &amp; in hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lumbal puncture

(Signed) John Horace G. Stewart, M. D.

1/26, 1922 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Mt. Auburn Cem.

Jan 29 1922

## 20 UNDERTAKER

Daniel Gustin

## ADDRESS

910 Penna Ave

CAUSE OF DEATH in plain terms, so that laymen can understand. See instructions on back of certificates.

AN 26 1922

Burial Permit Blank

(Walburga Schirmer)  
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60670

D 60670

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 S 3rd)ST.: 76 WARD) 179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Walburga Schirmer(a) RESIDENCE. NO. 701 S 3rd

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos.

How long in U. S., If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

August Schirmer

6 DATE OF BIRTH (month, day, and year)

May 12 - 1863

7 AGE

56

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Anton Bril

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Matron

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

August Schirmer  
701 S 3rd St

15

Filed

Robert F. Harrison

19

Registrar

Burial Permit Clerk!

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1/23 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan, 1917, to Jan 25 1922that I last saw her alive on Jan 24 1922and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH\* was as follows:

Hemophilia over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

High Blood Pressure Chon Int 1/26 1922 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. D. Hughes M. D.126 1922 Address 3323 E. Beach St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oak Lawn Cem. Jan 28 1922

20 UNDERTAKER

ADDRESS

Lilly and Ziehl 403 S. Wolfe

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Apoplectic*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60671

D 60671

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

57 yrs. 8 mos. 23 ds.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Henry E.

6 DATE OF BIRTH (month, day, and year)

May 1 - 1864

7 AGE

57

Years

Months

8

Days

23

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Frank Sanders.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ger.

12 MAIDEN NAME OF MOTHER

Anna Templar.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ger.

14

Informant (Address)

Henry E. 800 S. Linwood Ave.

Robert F. HARRISON,

19

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan. 24 1922

I HEREBY CERTIFY, that I attended deceased from Jan 10, 1922 to Jan 24, 1922 that I last saw him alive on Jan 24, 1922 and that death occurred, on the date stated above, at 11 A. M.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency.

CONTRIBUTORY (Secondary)

Cholera Throat.

18 Where was disease contracted? If not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Carmel Cem.

Jan. 27 1922

20 UNDERTAKER

Lilly and Ziehl

ADDRESS

403 S. W. Ave.

AN 86 1922



D 60672

## HEALTH DEPARTMENT—CITY OF BALTIMORE

60672

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 S Caroline

## 2-FULL NAME

(Residence in Baltimore: No. 10 S Caroline

ST.: 3 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. 12 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

F.

4-COLOR OR RACE

W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) S

6-DATE OF BIRTH

Jun

15

1912

(Month)

(Day)

(Year)

7-AGE

yrs. mos. 12 ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE, (State or Country).

10 S Caroline

10-NAME OF FATHER

Roy Graham

11-BIRTHPLACE OF FATHER (State or Country).

N.C.

12-MAIDEN NAME OF MOTHER

Virginia Smith

13-BIRTHPLACE OF MOTHER (State or Country).

N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Roy Graham

(Address)

10 S Caroline

15-

Robert P. Harrison,

Filed

AN 261922

Burial permit clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Jun

26

1912

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on Jan 26 1912

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage

CONTRIBUTORY (Secondary)

(Signed) Ralph A. Hoff

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Trinity Cem.

20-UNDERTAKER

Lilly + Ziller

DATE OF BURIAL

Jan. 27, 1912

ADDRESS

403 S. Wolfe

D 60673

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60673

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 Myrtle Ave)

ST. 17

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Robert Hucles

## (a) RESIDENCE

No. 1103 Myrtle Ave

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos.

ds. How long in U. S. if of foreign birth? yrs mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Jan 1 - 1887

## 7 AGE

85 Years

Months

25 Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Stock Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

John R. H. Co.

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

Samuel R. Hucles

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va.

## 12 MAIDEN NAME OF MOTHER

Clara Johnson

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant (Address)

George Hucles 203 W. 11th St.

## 15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) 1-20-1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan 24, 1922, to Jan 25, 1922, that I last saw him alive on Jan 25, 1922.

and that death occurred, on the date stated above, at 10:31 a.m.

The CAUSE OF DEATH\* was as follows:

Acute Indigestion over

(duration) yrs. mos. 1 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted If not at place of death?

Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

J. A. C. M. D.

19 (Address)

1163 Myrtle Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Laural Cnty

Jan 28 1922

## 20 UNDERTAKER

George H. Hollander

## ADDRESS

1631 Highland Ave

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

N 26 1922

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*History of having been  
on spurs. Also history  
of having eaten sourkrout.  
Probable cause of acute  
intestinal indigestion. Not  
stomach poisoning.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60674

## CERTIFICATE OF DEATH.

D 60674

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 mile Lane ST. 101 WARD)

## 2-FULL NAME Anne Smith

(a) RESIDENCE. NO. 7 mile Lane ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

5 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed,

or Divorced (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 23-1881

7 AGE

40 Years

9 Months

1 Days

If LESS than

1 day, hrs.

or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.

Teacher 068

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Md

10 NAME OF FATHER

Wm H. Smith

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Md

12 MAIDEN NAME OF MOTHER

Martha Harris

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md

14

Informant  
(Address)Martha Smith  
7 mile Lane

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 24 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 24 1922, to Jan 24 1922,

that I last saw him alive on Jan 24 1922,

and that death occurred, on the date stated above, at 130 m.

The CAUSE OF DEATH\* was as follows:

Tubercular Pneumonia

CONTRIBUTORY  
(Secondary)18 Where was disease contracted  
if not at place of death?

Home

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed) M. D.

1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Orlaburn Inty Jan 27 1922

20 UNDERTAKER

George H. Holland 1631 K Street

Hilman

CAUSE OF DEATH in plain terms. See instructions on back of certificates.  
TION is very important.



D 60675

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60675

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1409 Druid Hill Ave. ST. 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1409 Druid Hill Ave. 46 yrs., — mos., — ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE Col 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, May 6, 1875. (Month) (Day) (Year)

7-AGE, 46 yrs., 8 mos., 17 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Housekeeper (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balt Md

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss E. Stoll Pecker

(Address) 1409 Druid Hill Ave.

15-

Robert P. Harrison, Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 24, 1922. (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 17 1922 to Jan 24 1922, that I saw him alive on Jan 23 1922, and that death occurred, on the date stated above, 49 m. The CAUSE OF DEATH\* was as follows:

Interstitial Nephritis

(Duration) 6 yrs., — mos., — ds. CONTRIBUTORY (Secondary) Anaemia

(Signed) Dr. V. Carr M. D. (Address) 515 N. E. St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, — yrs., — mos., — ds. In the State, — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Ambrose Ch. DATE OF BURIAL, Jan 27, 1922

20-UNDERTAKER, Wm. A. Holland ADDRESS 1287

Harriet Hill

N. B.—Every item on this certificate is important. See instructions on back of certificate.

AN 2

D 60676

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60676

## CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1438 N Bond ST. 8 WARD)FULL NAME Emmard Rooker(Residence in Baltimore: No. 1438 N Bond

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. (4) yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M4-COLOR OR RACE W5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married6-DATE OF BIRTH Oct 26, 1877

(Month)

(Day)

(Year)

7-AGE 47

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Machinist(b) General nature of industry, business, or establishment in which employed (or employer). Chemical Co9-BIRTHPLACE, (State or Country), N.S.10-NAME OF FATHER, Es Rooker11-BIRTHPLACE OF FATHER (State or Country), N.S.12-MAIDEN NAME OF MOTHER Bessie James13-BIRTHPLACE OF MOTHER (State or Country), N.S.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Larry Rooker(Address) 1438 N Bond

15-

Filed

191

Registrar.

Burial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 26, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held and (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

and that said deceased came to death (Inquest, au-

The CAUSE OF DEATH\* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Robert F. Harrison M. D.

(Coroner)

121, 312 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Franklin AveDATE OF BURIAL, Aug 27, 192220-UNDERTAKER Bob James IncADDRESS 442 Broadway

D 60677 HEALTH DEPARTMENT—CITY OF BALTIMORE, D 60677

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Marlborough Apts. 14* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Fannie Ambach*

## (a) RESIDENCE. NO.

*Marlborough Apts.*

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

*Lifetime.*

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced (write the word)

*Female White Widow*

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*David Ambach*

## 6 DATE OF BIRTH (month, day, and year)

*June 24, 1848*

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*73 7 1*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*At home*

(b) General nature of industry, business, or establishment in which employed (or employer)

*800*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore Maryland*

## 10 NAME OF FATHER

*Benjamin Burgunder*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Germany*

## 12 MAIDEN NAME OF MOTHER

*Caroline Friedman*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Germany*

## 14

Informant  
(Address)*Harry Simbach  
Marlborough*

## 15

Billed

*Robert P. Harrison,*

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan. 25, 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*1897, to Jan 25, 1922.*that I last saw h. or alive on *Jan 25, 1922.*and that death occurred, on the date stated above, at *9 P m.*

The CAUSE OF DEATH\* was as follows:

*Mitral regurgitation*(duration) *25* yrs. mos. ds.CONTRIBUTORY  
(Secondary)*Arterio-sclerosis*(duration) *10* yrs. mos. ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *h* Date of *—*Was there an autopsy? *no*What test confirmed diagnosis? *Normal physical signs*(Signed) *Harry Webster* M. D.19 (Address) *1718 Eutaw Place*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Balto. Hebrew Cem.**1/27 1922*

## 20 UNDERTAKER

*David Sandheim*

## ADDRESS

*118 W. Mt. Royal Ave.*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

AN 26 1922

D 60678

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60678

## CERTIFICATE OF DEATH. X 44

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (Name of Hospital) ST. 7 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Edward J. Euker

## (a) RESIDENCE. NO.

4413 St S.W. Washington D.C.

## WARD.

Wash. D.C.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Unknown

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Widower

## 5a If married, widowed or divorced

HUSBAND of (or) WIFE of

Theresa H. Euker

## 6 DATE OF BIRTH (month, day, and year)

Oct. 6th-1863

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

58

3

19

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or other kind of work

Accountant

(b) Industry, at in

(c) Name of employer

R. H. Henderson

## 9 BIRTHPLACE (city or town) (State or country)

Virginia

## 10 NAME OF FATHER

Edward J. Euker

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Eleanora Kreck

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

## 14 Informant (Address)

JOHNS HOPKINS HOSPITAL.

## 15 Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan 25 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan 2nd, 1922, to Jan 25th, 1922,

that I last saw him alive on Jan 25th, 1922,

and that death occurred, on the date stated above, at 5:50 P.M.

The CAUSE OF DEATH\* was as follows:

Lung Abscess

(duration) yrs. 9 mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death? in Washington D.C.

Did an operation precede death? yes Date of 1/21/22

Was there an autopsy? yes

What test confirmed diagnosis? operation, Section Exam, X-ray

(Signed) George H. Henderson, M. D.

, 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park

## DATE OF BURIAL

Jan 27 1922

## 20 UNDERTAKER

Wm. Pickens &amp; Son N. &amp; Pa.

CAUSE OF DEATH in plain terms is very important. See instructions on back of certificates.

Partial Permit Blank



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Not tuberculous.*  
*Secondary to carcinoma*  
*of oesophagus.*

D 60679 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60679

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE (No. 2700 Mooker ST., 16 WARD)

## 2. FULL NAME

Virginia Camden Blazer

## (a) RESIDENCE NO.

12700 Mooker St

(Usual place of abode)

Length of residence in city or town where death occurred

10 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Charles W. Blazer

6 DATE OF BIRTH (month, day, and year)

Feb 12/1852

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

69

11

13

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Annapolis Md

10 NAME OF FATHER

Thomas M Camden

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Ely Taylor Camden

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant

(Address)

Mrs Maggie Rodman

2700 Mooker St

15

Filed

19

Registrar

Robert F. Harrison,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1922

17

I HEREBY CERTIFY, that I attended deceased from

Jan 21, 1922 to Jan 25, 1922

that I last saw him alive on Jan 24, 1922

and that death occurred, on the date stated above, at 5:00 A. M.

The CAUSE OF DEATH\* was as follows:

myocarditis, with acute dilatation of heart.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John S. Thibault M. D.

Address 1219 Poplar Road

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

London Park Cem

Jan 27, 1922

20 UNDERTAKER

Wm. Hickner Sons

ADDRESS

North Pa

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

JAN 26 1922

Baltimore Health Dept.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60680

D 60680

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Smith Ave West Baltimore* WARD) *25*2-FULL NAME *Sarah Miller Rittenhouse*(a) RESIDENCE No. *Smith Ave West Baltimore* ST. WARD(Usual place of abode) Length of residence in city or town where death occurred *80* yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *unknown*7 AGE Years *80* Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Bald Md*10 NAME OF FATHER *Charles Rittenhouse*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Penna*12 MAIDEN NAME OF MOTHER *Amelia Vaulusker*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Penna*14 Informant *James Rittenhouse* (Address) *West Wmans*

15 JAN 27 1922 ROBERT R. KRAUTER, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 25 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan 12*, 1922, to *Jan 25*, 1922, that I last saw him alive on *Jan 20*, 1922and that death occurred, on the date stated above, at *8-P* m.

The CAUSE OF DEATH\* was as follows:

*Myocardial infarction chronic arterial sclerosis*CONTRIBUTORY (Secondary) *Exhaustion* (duration) *7* yrs. mos. da.(duration) yrs. mos. *3* da.18 Where was disease contracted if not at place of death? *✓*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *none*(Signed) *Stanley French*, M. D.1/26/22 (Address) *10 W Carey, Jr.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL

*Landon Park Jan 27 1922*

20 UNDERTAKER ADDRESS

*John Orutchee 1201 W. Fayette St*

Information should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60681

## CERTIFICATE OF DEATH.

D 60681

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Southern Hospital* ST., *11* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Anna Stuart Broe*(a) RESIDENCE No. *1124 Madison Ave* ST., *11* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *46* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *widow*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Andrew C. Broe*6 DATE OF BIRTH (month, day, and year) *unknown*7 AGE Years *81* Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*England*

10 NAME OF FATHER

*Unknown*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Unknown*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Unknown*14 Informant *Mrs. Blanche E. Skinner*  
(Address) *2507 W. 11th St.*15 *ROBERT H. KRAUTER*

JAN 27 1922

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 28 1922*

17 I HEREBY CERTIFY That I attended deceased from

*1910* to *January 6 1922*that I last saw him alive on *January 3 1922*and that death occurred, on the date stated above, at *3-a. m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral arterio sclerosis  
(no hemorrhage)*(duration) *5* yrs. mos. ds.CONTRIBUTORY (Secondary) *Cerebral softening*(duration) *30* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Frank M. Seal* M. D.(Address) *8 + 30 Maryland Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*London Park Cem., Jan 28 1922*

20 UNDERTAKER ADDRESS

*John Mitchell 1301 W. Fayette St.*

Cause of Death in plain terms, so that it may be properly classified. See instructions on back of certificates.



D 60682 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60682

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1220 Penna Ave ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE

(Usual place of abode)

Length of residence in city or town where death occurred

50

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

69

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

JAN 27 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

HEREBY CERTIFY, that I attended deceased from Dec 22, 1921, to Jan 25, 1922

that I last saw her alive on Jan 23, 1922

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis  
Hypostatic Pneumonia  
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Arteriosclerosis  
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Biopsy  
(Signed) Chas. H. B. M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Monastkontolfs Landstrasse Jan 27 1922

20 UNDERTAKER

Samuel Hensley Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60683

## CERTIFICATE OF DEATH.

D 60683

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1516 W. Mount St. ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William T. Wesley

(a) RESIDENCE. NO.

1576 W. Mount St.

ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds.

(If nonresident, give city or town and State)

How long in U. S., if of foreign birth?

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary Wesley

6 DATE OF BIRTH (month, day, and year)

7 AGE

57

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Elkridge

10 NAME OF FATHER

John Wesley

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Elkridge

12 MAIDEN NAME OF MOTHER

Catherine Wesley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Elkridge

14 Informant (Address)

Mary Wesley  
1576 W. Mount St.

15

JAN 27 1922

ROBERT H. KRAUTER Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 21 1922

I HEREBY CERTIFY, that I attended deceased from Jan 21 1922, Jan 21 1922, Jan 21 1922, that I last saw him alive on Jan 21 1922, Jan 21 1922, Jan 21 1922, and that death occurred, on the date stated above, at 7:00 p. m.

The CAUSE OF DEATH\* was as follows:

Chor. Parac. pneumoniae hepatitis + mitral insufficiency

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical.

(Signed) Geo. H. Kasper, M. D.

(Address) 2215 N. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Wesley Co. Elkridge Jan 27 1922

20 UNDERTAKER

Samuel Shundy

DATE OF BURIAL

ADDRESS

Biddle

D 60684

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3101 Guilford Avenue ST. 12 WARD)

2-FULL NAME Robert W. Macdonald

(a) RESIDENCE. NO. 3101 Guilford Avenue ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 11 mos. 29 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Mary J. Myers

6 DATE OF BIRTH (month, day, and year) Jan. 26, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	11	29	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Secretary

(b) General nature of industry, business, or establishment in which employed (or employer)

Baltimore American

(c) Name of employer

Fire Insurance Co.

9 BIRTHPLACE (city or town)  
(State or country)Baltimore  
Maryland

10 NAME OF FATHER James H. Macdonald

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Baltimore  
Maryland

12 MAIDEN NAME OF MOTHER Anna E. Grothaus

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Baltimore  
Maryland14 Informant Mrs. Mary J. Macdonald  
(Address) 3101 Guilford Avenue

15 Filed 19

JAN 27 1922

ROBERT R. KANTER  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1921 to Jan 28 1922, that I last saw him alive on Jan 28 1922, and that death occurred, on the date stated above, at 10:30 p.m. The CAUSE OF DEATH\* was as follows:

Cirrhosis of Liver

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

Pulm. Congestion

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. F. Blake, M. D.

Jan 1922 (Address) 208 Presb.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Druid Ridge Cemetery

DATE OF BURIAL

1/28/22<sup>19</sup>

20 UNDERTAKER

Henry W. Mears &amp; Son 805 N. Calvert

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60685

## CERTIFICATE OF DEATH.

D 60685

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes Hospital* ST. *20* WARD)

## 2. FULL NAME

(a) RESIDENCE NO. *295 S. Pulaski St.* ST. *11* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *65* yrs. mos. ds.How long in U. S., if of foreign birth? *65* yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F.* 4 COLOR OR RACE *W.* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*5a If married, widowed, or divorced, HUSBAND of (or) WIFE of *Widow Michael Frost*6 DATE OF BIRTH (month, day, and year) *Dec 12 1841*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *80 yrs. 1*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*(b) General nature of industry, business, or establishment in which employed (or employer) *ooo*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *Adam Stein*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Elaine*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14

Informant (Address) *Adolph Frost, Jr. 1710 S. Lemon St.*

15

JAN 27 1922

ROBERT R. KRANTZ

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 26 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan. 25*, 19*22*, to *Jan. 26*, 19*22*, that I last saw him alive on *Jan. 26*, 19*22*, at *4:40 A.M.*

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

*Cholecystitis with stones - Empyema of Gall Bladder - Ruptured Gall Bladder - Peritonitis - Intestinal Obstruction - not known*CONTRIBUTORY (Secondary) *Cardiac failure - pulmonary edema*18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *yes* - Date of *1-25-22*Was there an autopsy? *no*What test confirmed diagnosis? *operation*  
(Signed) *W. C. Caldwell*, M. D.  
, 19 (Address) *St. Agnes Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*St. Agnes Cemetery* Jan 28 1922  
ADDRESS *William Beck 502 E North*

Information should be carefully supplied so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.



(See Affidavit over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60686

CERTIFICATE OF DEATH.

D 60686

PLACE OF DEATH

CITY OF BALTIMORE (No. 19 E. York St.

St.: 22 WARD)

REGISTERED No. C

2-FULL NAME

Morris Krone.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

19 E. York St.

30 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male. 4-COLOR OR RACE, White. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)

6-DATE OF BIRTH, Jan 25, 1870 (Month) (Day) (Year)

7-AGE, 52 If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Oculist. (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Russia.

10-NAME OF FATHER, Sidney Krone.

11-BIRTHPLACE OF FATHER (State or Country), Russia.

12-MAIDEN NAME OF MOTHER, Anna.

13-BIRTHPLACE OF MOTHER (State or Country), Russia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dora Krone. (wife)

(Address) 19 E. York St.

15- JAN 27 1922

Filed

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 26th, 1922, 191 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

(thereon and from the evidence obtained by and inquiry And that said deceased came to death topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cerebral Apoplexy.

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. da.

(Signed) M. D. (Coroner)

Jan. 27th 1922 (Address) 1017 S. Charles St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. da. In the State, yrs. mos. da.

Where was disease contracted, if not at place of death.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Jan 27, 1922

20-UNDERTAKER, ADDRESS, 121 E

John Washington Rd Balto St

N. B.—Every item of information furnished to the Health Department is subject to inspection by the Bureau of Vital Statistics. See instructions on back of certificate.

See affad.

State of Maryland, *Baltimore City* to wit:

BE IT REMEMBERED, That on this *27<sup>th</sup>* day of *January*  
A. D., 19*22*, before me the subscriber, a *Justice of the Peace*  
of the said state, in and for the *city* aforesaid, personally appeared

*Dora B. Krone*  
*Residing 19 E. York Street Balto Md*  
and made oath in due form of law that *she is the wife of Morris*  
*Krone deceased That from family record*  
*The deceased was born on the 25<sup>th</sup> day of*  
*January 1870 in Russia, and his correct age*  
*being 52 years and 1 day - That the age*  
*given by the Undertaker and stated on the*  
*death certificate is wrong.*

*Signed*  
*Dora B. Krone*  
*her*  
*X*  
*mark*

*Julius G. Guide J.P.*

MY COMMISSION EXPIRES MAY 4, 1922

JAN 27 1922

D 60687

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

D 60687

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

3940 Park Heights St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Sarah E. Koel

(Residence in Baltimore: No.

3940 Park Heights Ave. St. 80 yrs. — mos. — ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE.

White

5-STATUS  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)  
Widow

## 6-DATE OF BIRTH.

May 26, 1841  
(Month) (Day) (Year)

## 7-AGE.

80 yrs. 7 mos. 30 ds.  
If LESS than 1 day,  
...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,  
(State or Country).

Baltimore Md

## 10-NAME OF FATHER.

John J. Rothrock

11-BIRTHPLACE OF FATHER  
(State or Country).

Pennsylvania

## 12-MAIDEN NAME OF MOTHER

Margaret Agnew

13-BIRTHPLACE OF MOTHER  
(State or Country).

Baltimore Md

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ...

(Address) ...

## 15-

JAN 27 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan 25, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Jan 13, 1922, to Jan 25, 1922,

that I saw him alive on Jan 25, 1922,

and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH\* was as follows:

Hypostatic congestion of lungs

(Duration) ... yrs. ... mos. ... ds. 3 1/2

CONTRIBUTORY  
(Secondary)

Bronchitis

(Signed) ... M. D.

Jan 26, 1922 (Address) ...

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Mt O Live

## DATE OF BURIAL,

Jan 28, 1922

## 20-UNDERTAKER

Geo W Little

## ADDRESS

Edmondson Ave

CAUSE OF DEATH in plain terms on back of certificate. important. See instructions on back of certificate.

D 60688

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

90 D 60688

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1025 Wilhelm St.)

2-FULL NAME Sarah R. True

(Residence in Baltimore: No. 1025 Wilhelm St.)

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female

4-COLOR OR RACE White

5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word) Widowed

6-DATE OF BIRTH April 23, 1850

7-AGE 71

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9-BIRTHPLACE (State or country) Baltimore, Md

10-NAME OF FATHER George E. Lusby

11-BIRTHPLACE OF FATHER (State or country) Ind

12-MAIDEN NAME OF MOTHER Mary Lusby

13-BIRTHPLACE OF MOTHER (State or country) Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas H. True

(Address) 1025 Wilhelm St

15-

FILE

101

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Jan. 26, 1922

17- I HEREBY CERTIFY, That I attended deceased from April 27, 1922, to Jan. 26, 1922, that I saw her alive on Jan. 26, 1922, and that death occurred, on the date stated above, at 6:10 P.M.  
The CAUSE OF DEATH\* was as follows:  
Mitral Valvular lesion of heart.

Contributory (SECONDARY)

Cant say

(Signed) C. H. Carr

Jan 26, 1922

[Address] 1215 Hanover St.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Solomon's Calvary

20-UNDERTAKER

John H. Denny

DATE OF BURIAL

Jan 28, 1922

ADDRESS

715 Light

N. B.—Every item of information should be carefully checked, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. TION is very important.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

60689

D 60689

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1922 E Fayette ST., 6 WARD)

## 2-FULL NAME

Thomas J. Dobson

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE No.

1922 E Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

80 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

Life

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Amelia T. Dobson

## 6 DATE OF BIRTH (month, day, and year)

March 16, 1837

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

84

10

11

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Retired Employee

## (b) General nature of industry, business, or establishment in which employed (or employer)

of Penn. R. R.

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

St. Michael's

## 10 NAME OF FATHER

Macy

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Not Known

## 12 MAIDEN NAME OF MOTHER

Not Known

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Not Known

## 14

Informant (Address)

Mrs. Amelia T. Dobson 1922 E Fayette St.

## 15

Filed

JAN 27 1922

J. E. W. W. W.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan. 27, 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan 5, 1922, to Jan 27, 1922.

That I last saw him live on Jan. 27, 1922.

and that death occurred, on the date stated above, at 12-0 m.

The CAUSE OF DEATH\* was as follows:

Severe Bronchitis

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. W. W. W., M. D.

(Address) 14376 13 May

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION, OR RE-

National Cemetery

UNDERTAKER

Henry Horan

## DATE OF BURIAL

Jan. 30, 1922

## ADDRESS

1301 E Fayette



D 60691

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60691

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hosp.* ST.: *9* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. *Elliott City, Md.* ST.: *2* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *2* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed,

or Divorced (write the word)

*Married*

5a. If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Unknown*

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*41*

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*labor*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Maryland*

10 NAME OF FATHER

*John Cawley*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Maryland*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Unknown*

14

Informant  
(Address)*Hospital Record*

15

Filed

*JAN 27 1922**J. E. Wilm* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan. 27* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan. 24*, 19 *22*, to *Jan. 27*, 19 *22*,that I last saw him alive on *Jan. 27*, 19 *22*,and that death occurred, on the date stated above, at *4:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*acute nephritis*(duration) yrs. mos. *5* ds.CONTRIBUTORY  
(Secondary)*Bronchial Asthma*(duration) *25* yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

*at home*

Did an operation precede death?

*No* Date of

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Autopsy: Bl. Urea.*

(Signed)

*Frank C. Marino*, M. D.

, 19

(Address)

*St. Joseph's Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Oella Cem. Balt. Co.**Jan. 29* 19 *22*

20 UNDERTAKER

*Easton Sons*

ADDRESS

*Elliott City*

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Chronic nephritic  
condition Acute  
attack*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60692

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *19* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Hadlan Armstrong*(a) RESIDENCE. NO. *111 N. Sticker St.* ST. \_\_\_\_\_ WARD. \_\_\_\_\_

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *8* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M.* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

*Mrs. Ella Armstrong*6 DATE OF BIRTH (month, day, and year) *1/18*7 AGE Years *55* Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Salesman*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Commercial*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Miss*10 NAME OF FATHER *Koryman Armstrong*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Miss*12 MAIDEN NAME OF MOTHER *Martina Lagrone*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Miss*14 Informant *Mrs. Ella Armstrong* (Address) *111 N. Sticker St.*15 *JAN 27 1922* ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan. 26, 1922*17 I HEREBY CERTIFY, That I attended deceased from *1/18*, 1922, to *1/26*, 1922.that I last saw him alive on *Jan. 25*, 1922.and that death occurred, on the date stated above, at *1 A. M.*

The CAUSE OF DEATH\* was as follows:

*Hemiplegia. Chronic diffuse nephritis.*(duration) yrs. mos. *9* da.CONTRIBUTORY *Pulmonary Congestion.* (Secondary)(duration) yrs. mos. *2* da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of \_\_\_\_\_Was there an autopsy? *Yes*What test confirmed diagnosis? *Laboratory*(Signed) *J. Willis Gustaf*, M. D., 19 (Address) *University Hospital.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Dade City Florida*

20 UNDERTAKER

*W M Routson*

ADDRESS

*Green & Son*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assoc.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Terminal hemorrhage  
which caused death*

D 60693

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 W. Saratoga ST., 4 WARD)

## 2-FULL NAME

Theresa M. Byness

## (a) RESIDENCE NO.

421 W. Saratoga ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

3 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

Female WhiteSingle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

unknown

## 7 AGE

Years

Months

Days

If LESS than 1 day, ... hrs. or ... min.

52

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Maryland

## 10 NAME OF FATHER

Peter Byness

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

## 12 MAIDEN NAME OF MOTHER

Mary M. Nieve

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

## 14

Informant (Address)

John Byness  
421 W. Saratoga St.

## 15

Filed

JAN 27 1922ROBERT K. KRAUTER,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan 26 1922

## 17

HEREBY CERTIFY, That I attended deceased from

Jan 17 1922 to Jan 26 1922,that I last saw him alive on Jan 26 1922,and that death occurred, on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH\* was as follows:

Acute nephritis(duration) yrs. mon. 10 ds.

## CONTRIBUTORY (Secondary)

Chronic nephritis(duration) yrs. mon. not known ds.

## 18 Where was disease contracted

if not at place of death?

not known

Did an operation precede death?

no

Date of

Was there an autopsy?

yes

What test confirmed diagnosis?

Urinary Analysis

(Signed)

Charles O'Donnell, M. D.

(Address)

5 E. Read St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

## DATE OF BURIAL

Cathedral Cemetery1/28 1922

## 20 UNDERTAKER

ADDRESS

James J. Evans & Son 118 W. N. Ave.John

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60694

## CERTIFICATE OF DEATH.

D 60694

## 1-PLACE OF DEATH

CITY OF BALTIMORE

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ST.

WARD.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant

(Address)

15

File

JAN 27 1922

ROBERT N. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH\* was as follows

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 ADDRESS

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60695

## CERTIFICATE OF DEATH.

D 60695

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2100 E. Balto. ST. 6 WARD)

## 2. FULL NAME

(a) RESIDENCE NO. 2100 E. Balto.

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 20 yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 COLOR OR RACE

5 Single, Married, Widowed, Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

102

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14

Informant (Address) J. Lewis 1411 E. Balto. St.

15

JAN 27 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan. 1922, 1922, to Jan. 26, 1922.

that I last saw her alive on Jan. 26, 1922.

and that death occurred, on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH\* was as follows:

(1) Arterio-sclerosis

(2) Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Lewis M. D.

, 19 (Address) 1342 1/2 East Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Helen Rosdall

20 UNDERTAKER

Jack Lewis

DATE OF BURIAL

1-27 1922

ADDRESS

1411 E. Balto. St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60696

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

to 1922, to Jan 26, 1922,

that I last saw him alive on Jan 26, 1922,

and that death occurred, on the date stated above, at 5 m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Williams, M. D.

27, 1922 (Address) #224 Brady

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly transcribed. See instructions on back of certificates.

JAN 27 1922

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior.*

## HEALTH DEPARTMENT--CITY OF BALTIMORE

D 60697

## CERTIFICATE OF DEATH.

D 60697

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1707 Ashbury St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kenneth L. Tweeddale

(Residence in Baltimore: No. 1707 Ashbury St.)

St.: yrs., 1 mos. 29 (da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

single

6-DATE OF BIRTH,

Nov. 28, 1910  
(Month) (Day) (Year)

7-AGE,

3 yrs., 1 mos., 29 da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)unemployed  
(Defendant)9-BIRTHPLACE,  
(State or Country),

Baltimore, Md.

10-NAME OF FATHER,

Albert L. Tweeddale

11-BIRTHPLACE OF FATHER  
(State or Country),

Baltimore, Md.

12-MAIDEN NAME OF MOTHER

Katherine Falk

13-BIRTHPLACE OF MOTHER  
(State or Country),

Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A. L. Tweeddale

(Address) 1707 Ashbury St.

15-

Filed

JAN 27 1922

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan. 26, 1922  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) (mass) in abdomen

(Duration) yrs. mos. da.

(Signed) J. T. Hennessy M. D.

(Coroner.)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Woodlawn

DATE OF BURIAL,

Jan 28 1922

20-UNDERTAKER

Finkler &amp; Finkler

ADDRESS

1738

Gager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. See instructions on back of certificate.



✓  
LTIMORE 001  
101-001  
D.60698

**CERTIFICATE OF DEATH.**

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 742 N. W. Washington ST., WARD 1  
(Usual place of abode) 6 1 8 (If no

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 3 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1972

17 I HEREBY CERTIFY, That I attended deceased from  
Jan 10, 1922, to Jan 26, 1922,  
that I last saw her alive on Jan 25, 1922

and that death occurred, on the date stated above, at 1205 A. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Oedema

(duration) 1 yrs. 4 mos 4 da

CONTRIBUTORY (Secondary) *Robert V. Neumann*  
*Migratory* (duration) \_\_\_\_\_ yrs. mos. *13* ds

18 Where was disease contracted  
if not at place of death?.....

Did an operation precede death? No Date of \_\_\_\_\_

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Dr. G. G. G. G., M.D.

1/26, 1922 (Address) 203 E. Fulton St

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL	DATE OF BURIAL
1900	

20 UNDERTAKER	ADDRESS
Junkler & Junkler E. J. B.	Eager

JAN 27 1959

D 60699 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

113 D 60699

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 34 Powers

ST. 13 WARD)

## 2. FULL NAME

Edward Allen Neal

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

839 Powers

ST. 13 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Birth

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

Male White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

## 6 DATE OF BIRTH (month, day, and year)

Dec 13 1921

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1 13

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

M.D.

## 10 NAME OF FATHER

Irvin Neal

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

M.D.

## 12 MAIDEN NAME OF MOTHER

Kate Hale

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

M.D.

## 14

Informant (Address)

Irvin Neal 839 Powers St

## 15

JAN 27 1922

ROBERT B. KRAUTER, Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan 26 1922

I HEREBY CERTIFY, that I attended deceased from Jan 25 1922 to Jan 26 1922.

that I last saw him alive on Jan 26 1922.

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH\* was as follows:

Intestinal Cuts into scabion - Convulsions

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Harry E. Alperin M. D.

Address 13640 Roland Dr

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Woodlawn Jan 28 1922

## 20 UNDERTAKER

## ADDRESS

Cheroweth Son Chester

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST.: *7* WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*?*6 DATE OF BIRTH (month, day, and year) *Sep 17, 1872*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*49**4**8*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Planter*

(b) General nature of industry, business, or establishment in which employed (or employer)

*?*

(c) Name of employer

*?*

9 BIRTHPLACE (city or town) (State or country)

*Jamaica West Indies*

10 NAME OF FATHER

*Mattren Benjamin*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Jamaica*

12 MAIDEN NAME OF MOTHER

*Mamuelita Zeringa*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Spain*

14

Informant (Address)

*Johns Hopkins Hospital*

15

Filed

*Robert P. Harrison,*

Registrar

*Deputy Permit Clerk.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 25* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

*Dec 19*, 19*21*, to *1-25*, 19*22*,that I last saw him alive on *1-25*, 19*22*,and that death occurred, on the date stated above, at *4:00 p.m.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of stomach*(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) *2* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*Unknown*Did an operation precede death? *Yes* Date of *Dec 27, 1921*Was there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Emile Holman* M. D.

19 (Address)

*Johns Hopkins Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St Vincent**Jan 28, 1922*

20 UNDERTAKER

ADDRESS

*Joseph Ahrens**22 N Broadway*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N 27 1922

D 60701 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60701

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Morrow Hospital*  
CITY OF BALTIMORE: (No. *1122 N. Mount* ST., *13* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *John H. Jackson*(a) RESIDENCE NO. *320 Fall Rd.*

(Usual place of abode)

ST.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *35* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced, (write the word) *Widower*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Ann Jackson (deceased)*6 DATE OF BIRTH (month, day, and year) *April*

7 AGE

Years

Months

Days

If LESS than  
1 day, .... hrs.  
or .... min.*About 70*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Day Labor*

(b) General nature of industry, business, or establishment in which employed (or employer)

*at Aberdeen Md*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*North Carolina*10 NAME OF FATHER *asked not known*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*asked not known*12 MAIDEN NAME OF MOTHER *asked not known*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*asked not known*

14

Informant

(Address)

*Maud Hall  
320 Belmont Ave Fall Rd*

15

Filed

19

19

*Robert F. Harrison,*

Registrar

*Special Permit Clerk*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan. 25 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*12-7-1921*, to *1-25-1922*that I last saw him alive on *1-25-1922*and that death occurred, on the date stated above, at *11 a m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Nephritis  
Myocarditis*CONTRIBUTORY  
(Secondary)

(duration) ? yrs. mos. ds.

*Hypertrophy of Prostate*

(duration) 3-4 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

*at home*

Did an operation precede death?

*yes* Date of *12-30-21*

Was there an autopsy?

*yes + partial*

What test confirmed diagnosis?

(Signed) *Howard P. Tolson* M. D.

19

(Address)

*1122 N. Mount St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*St John Church**Jan 29 1922*

20 UNDERTAKER

*H. B. Marshall 3539 Fall Rd*

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

JAN 27 1922



**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Operation for relief  
of urinary obstruction*

D 60702

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60702

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No.

## 2-FULL NAME

(Residence in Baltimore) No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

## 4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

## 6-DATE OF BIRTH,

## 7-AGE,

If LESS than 1 day,

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE, (State or Country),

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER (State or Country),

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER (State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

Robert P. Harrison,

Burial Permit Clerk. Registrar.

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an

thereon and from the evidence obtained by said

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

## CONTRIBUTORY (Secondary)

(Signed) J. C. Kennedy, M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

## Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

## 20-UNDERTAKER

ADDRESS

Every item of information should be extremely supplied. Accurate statement of OCCUPATION is very important. See instructions on back of certificate.

1922

D 60703 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60703

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3307 Elgin Avenue ST.: 13 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Judge

(a) RESIDENCE. No. 3307 Elgin Avenue ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Joseph C. Judge

6 DATE OF BIRTH (month, day, and year) Feb. 4, 1880

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 41 11 22

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. (State or country) Maryland

10 NAME OF FATHER George W. Cox

11 BIRTHPLACE OF FATHER (city or town) Baltimore Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane B. Hoshall

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co., (State or country) Maryland

14 Informant. Joseph C. Judge (Address) 3307 Elgin Ave., Walbrook

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1922, to Jan 26, 1922, that I last saw her alive on Jan 26, 1922, and that death occurred, on the date stated above, at 4:45 a. m.

The CAUSE OF DEATH\* was as follows:

Post-Partum Hemorrhage

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 hour Child-birth 3 hrs

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1/27, 1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

1/28/22 19

20 UNDERTAKER

ADDRESS

Henry W. Mears &amp; Son 805 N. Calvert

D 60704

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60704

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1155 Leachman ST. 16 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. 1155 Leachman ST.,

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs.  mos.  ds. How long in U. S., if of foreign birth?  yrs.  mos.  ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE C. 5 Single, Married, Widowed, or Divorced (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arsonius Coates6 DATE OF BIRTH (month, day, and year) Oct 24, 18417 AGE Years 80 Months 3 Days 2 If LESS than 1 day,  hrs.  or  min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Too Aged, none(b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer 9 BIRTHPLACE (city or town) (State or country) Virginia10 NAME OF FATHER Thomas Davis11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia12 MAIDEN NAME OF MOTHER Mahaley Jones13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia14 Informant (Address) Laura Martin  
1155 Leachman15 Filed Robert F. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 192217 HEREBY CERTIFY, That I attended deceased from January 23, 1922, to Jan 26, 1922, that I last saw her alive on Jan 26, 1922, and that death occurred, on the date stated above, at 2:10 A. m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis  
(duration) 2 yrs.  mos.  ds.CONTRIBUTORY (Secondary) Aged -  
(duration)  yrs.  mos.  ds.18 Where was disease contracted If not at place of death? ✓Did an operation precede death? No Date of Was there an autopsy? NoWhat test confirmed diagnosis? Physical  
(Signed) William H. Wright M. D.(Address) 1204 Presbman

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Merrill PointJan 27 1922

20 UNDERTAKER

ADDRESS

Chase & Son

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N 87 1922

Burial Permit Clerk.



D 60705

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60705

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Philadelphia Road and Bowley Lane* ST. *90* WARD)

## 2-FULL NAME

*John Rettiger*

## (a) RESIDENCE NO.

*Philadelphia Road & Bowley Lane*

WARD

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Divorced*

## 5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

*Eusthorine Rettiger*

## 6 DATE OF BIRTH (month, day, and year)

*March 10, 1864*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*67**10**15*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Farmer (Retired)*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Truck Farm*

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Balto. Co. Maryland*

## 10 NAME OF FATHER

*John B. Rettiger*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*

## 12 MAIDEN NAME OF MOTHER

*Unknown*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Unknown*

## 14

Informant (Address)

*John Bortenfelder Philadelphia Road & Bowley Lane*

## 15

*Robert P. Garrison*

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*Jan 25, 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*Jan 20, 1922, to Jan 20, 1922,*that I last saw him alive on *Jan 25, 1922,*and that death occurred, on the date stated above, at *10:30 P. m.*

The CAUSE OF DEATH\* was as follows:

*Mitral Regurgitation*

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

*John Lutheran Cemetery**Jan 28, 1922*

## 20 UNDERTAKER

*Wm. L. Lissner & Sons*

## ADDRESS

*Fulberton Md.*

AN 27 1922

Permit Clerk

mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 60706 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 D 60706

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 520 E 22nd

ST.: 9

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME Benjamin Franklin Bond.

## (a) RESIDENCE. No. 520 E 22nd

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Widowed

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Sarah J. Bond.

## 6 DATE OF BIRTH (month, day, and year)

Mch. 26-1896

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

89 10

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore.

## 10 NAME OF FATHER

Isiah Bond.

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Baltimore.

## 12 MAIDEN NAME OF MOTHER

Mary Blaney

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Baltimore.

## 14

Informant  
(Address)Mrs. Bill  
520 E 22nd St.

## 15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan 26 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

about 1917 to Jan 26 1922

that I last saw him alive on Jan 25 1922

and that death occurred, on the date stated above, at 4:20 P. M.

The CAUSE OF DEATH\* was as follows:

Cardiac dilatation following  
myocarditis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

## 18 Where was disease contracted

If not at place of death?

Potomac Neck, Balt. Co.

Did an operation precede death? ☒ Date ofWas there an autopsy? ☒

What test confirmed diagnosis?

(Signed) N. A. Wright, M. D.

Jan 27 1922 Address) 1014 S. Ellwood Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Oak Lawn Cemetery Jan 29 1922

## 20 UNDERTAKER

## ADDRESS

H. E. Hughes 414 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

27 1922

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Possibly chronic  
nephritis.*

D 60707

HEALTH DEPARTMENT—CITY OF BALTIMORE 001 D 60707

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt. Hope RetreatST. 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MISS ALICE CONNELLY(a) RESIDENCE. No. Mt. Hope RetreatST. 28 WARD. (Portsmouth, Va.)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 19 ds. How long in U. S., if of foreign birth? 59 yrs. 11 mos. 11 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

(Single)6 DATE OF BIRTH (month, day, and year) Feby-16-1862

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

591111

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

None

9 BIRTHPLACE (city or town) (State or country)

Ottawa  
Illinois10 NAME OF FATHER John G. Connelly11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known  
Ireland12 MAIDEN NAME OF MOTHER Ellen O'Donnell13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known  
Ireland

14

Informant Records of Mt. Hope Retreat  
(Address) Baltimore Md.

15

AN 27 1922

19

Special Permit Work, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 8, 1922, to Jan 26, 1922 that I last saw him alive on Jan 26th, 1922 and that death occurred, on the date stated above, at 11:50 P. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage(duration) 0 yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary)

Chronic Mania(duration) 24 yrs. 0 mos. 0 ds.18 Where was disease contracted if not at place of death? Richmond VaDid an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery M. D.  
Jan 27, 1922 (Address) Mt Hope Retreat

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Portsmouth, Va.Jan-27-22

20 UNDERTAKER

ST. MARTIN & MOWEN COMPANY  
(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.



D 60708

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60708

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

Belvedere Hotel

ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Moses Crystal

(a) RESIDENCE. NO.

319 W. 89th St

ST.,

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

4 mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Isabel Silverman Crystal

6 DATE OF BIRTH (month, day, and year)

March 13, 1865

7 AGE

Years

Months

Days

56 yrs

10

15

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Builder 116

(b) General nature of industry, business, or establishment in which employed (or employer)

Building Operator

(c) Name of employer

(self) Poland

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

Philip Crystal

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Poland

12 MAIDEN NAME OF MOTHER

Hannah Silverman

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Poland

14

Informant  
(Address)Isaac Crystal  
17-E-97th St

15

Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 27th 1922

17

I HEREBY CERTIFY, That I attended deceased from

Dec 17th 1921 to Jan 27th 1922

that I last saw him alive on Jan 27th 1922

and that death occurred, on the date stated above, at 2:15 p.m.

The CAUSE OF DEATH\* was as follows:

Cancer of Prostate

(duration) yrs. 8 mos. ds.

CONTRIBUTORY  
(Secondary)Pulmonary edema  
(duration) yrs. 3 mos. ds.18 Where was disease contracted  
if not at place of death?

New York N.Y.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

19 (Address)

Dr. J. H. Jones, M.D.  
1100 N. Charles St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Brooklyn N.Y.

June 27 1922

20 UNDERTAKER

Linda Bonheim

1180 N. Charles St

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates. TION is very important.

AN 87 1922 Burial Permit Clerk.

D 60709

HEALTH DEPARTMENT—CITY OF BALTIMORE, D 60709

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1419 Edmondson Ave ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mary E. Bowen

## (a) RESIDENCE. NO.

1419 Edmondson Ave ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Widow

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofDavid H. Bowen

## 6 DATE OF BIRTH (month, day, and year)

Apr. 16-1853

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.68910

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

own House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)NorthCarolina

## 10 NAME OF FATHER

Wm H. Atkinson11 BIRTHPLACE OF FATHER (city or town)  
(State or country)North Carolina

## 12 MAIDEN NAME OF MOTHER

Capeland13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)North Carolina

## 14

Informant  
(Address)Theodore Bowen (son)  
245 N. Monroe St.

## 15

Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1922

17 I HEREBY CERTIFY, That I attended deceased from

Jan 23, 1922, to Jan 26, 1922,that I last saw her alive on Jan 25, 1922,and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia(duration) yrs. mos. 4 ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt. J. Murray, M. D.(Address) 1510 N. Fremont Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Lowdon Park

## DATE OF BURIAL

Jan 28 1922

## 20 UNDERTAKER

Chas F. WasmusADDRESS 2039W. Pratt

CAUSE OF DEATH in plain terms, so that it may be properly transcribed. See instructions on back of certificates.

N 27 1922

Serial Permit Clerk.

D 60710

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60710

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2020 N. Payson* ST. *15* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*William Wiseman*(a) RESIDENCE. NO. *2020 N. Payson* ST. *15* WARD. *15*  
(Usual place of abode) (If nonresident give city or town and State)Length of residence in city or town where death occurred *59* yrs. *2* mos. *26* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced  
HUSBAND of *Catherine Wiseman*  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Oct. 31, 1862*7 AGE Years *59* Months *2* Days *26* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Carpenter*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country)10 NAME OF FATHER *John Wiseman*11 BIRTHPLACE OF FATHER (city or town) *Baltimore*  
(State or country)12 MAIDEN NAME OF MOTHER *Elizabeth Miller*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore*  
(State or country)14 Informant *Catherine Wiseman*  
(Address) *2020 N. Payson St.*15 Filed *Robert P. Harrison* Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan. 26, 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan. 25*, 1922, to *Jan. 26*, 1922, that I last saw him alive on *Jan. 26*, 1922, and that death occurred, on the date stated above, at *7* m.  
The CAUSE OF DEATH\* was as follows:  
*Broncho-Pneumonia*  
(duration) yrs. mos. *3* ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *no*Was there an autopsy? *no*What test confirmed diagnosis? *Physical signs*(Signed) *R. P. Harrison* M. D.1/27/22 Address *1903 W. North Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Western Cem* DATE OF BURIAL *Jan 30*20 UNDERTAKER *Harry W. Ehlert* ADDRESS *1944 W. North Ave.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AN 87 1922

D 60711

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60711

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 345 S. Stricker St. ST. 19 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Guy Stone Ellis

## (a) RESIDENCE NO.

345 S. Stricker St.

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 1860

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

61

2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman, Baltimore

(b) General nature of industry, business, or establishment in which employed (or employer) City Fire Dept.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Md.

10 NAME OF FATHER John T. Ellis

11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country) Md.

12 MAIDEN NAME OF MOTHER Annie M. Courtney

13 BIRTHPLACE OF MOTHER (city or town) Washington  
(State or country) D.C.14 Informant Thomas W. Ellis  
(Address) 345 S. Stricker St.

15 Robert F. Harrison,

Burial Permit Clerk Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26<sup>n</sup> 1922

17 I HEREBY CERTIFY That I attended deceased from

Dec 12, 1920, to Jan 26, 1922.

that I last saw him alive on Jan 26, 1922.

and that death occurred, on the date stated above, at 12.45A.m.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart Disease

(duration) 14 mos. ✓ ds.

CONTRIBUTORY  
(Secondary)

(duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Jan. 26<sup>n</sup> 1922

Address 1203 W. Fayette St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE- DATE OF BURIAL

Louis Park Co Jan. 28, 1922

20 UNDERTAKER ADDRESS

Joseph B. Cook 1203 W. Fayette St.

mation should be carefully supplied so that it may be properly classified. Exact statement of OCCUR-  
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.  
TION is very important.

AN 27 1922



D 60712

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60712

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2941 Fait Avenue ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Thomas W. Adams Sr.

(a) RESIDENCE No. 2941 Fait Avenue ST., WARD  
(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura V. Adams

6 DATE OF BIRTH (month, day, and year) Feb. 17<sup>th</sup> 1946

7 AGE 75 Years 11 Months 8 Days 11 LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer Sanford and Brooks

9 BIRTHPLACE (city or town) A.A.CO. (State or country) Maryland

10 NAME OF FATHER Thomas W. Adams

11 BIRTHPLACE OF FATHER (city or town) A.A.Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sophia C. Johnson

13 BIRTHPLACE OF MOTHER (city or town) A.A.Co (State or country) Maryland

14 Informant Alfred Adams (Address) 3823 Fait Ave.

15 Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25<sup>th</sup> 192217 I HEREBY CERTIFY, That I attended deceased from Aug. 15<sup>th</sup> 1922 to Aug. 25<sup>th</sup> 1922, that I last saw him alive on Jan. 25<sup>th</sup> 1922, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH\* was as follows:

Enlarged Prostate  
Chronic Interstitial Nephritis

CONTRIBUTORY (Secondary) (duration) 2 yrs. mos. ds. Maenig Cmc

18 Where was disease contracted if not at place of death? Daid

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary ex.

(Signed) Lloyd O. O'Brien, M. D.

(Address) 6 N. My

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt. Carmel Cemetery

20 UNDERTAKER Joseph B. Cook

DATE OF BURIAL

Jan. 28 1922

ADDRESS 1003 N. Baltimore

mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

AN 87 1922

Permit Clerk?

D 60713

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 60713

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1416 Ramsay* ST.: *19<sup>th</sup>* WARD)2-FULL NAME *Mary Marguerite Cooper*(a) RESIDENCE. NO. *1416 Ramsay* ST., *19<sup>th</sup>* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *15* yrs. *3* mos. *15* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*female*

4 COLOR OR RACE

*white*

5 Single, Married, Widowed, or Divorced (write the word)

*Single.*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *October 12, 1906*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*15**3**15*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Inspector*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Manuf. of shirts.*

(c) Name of employer

*Vindex Shirt Factory*

9 BIRTHPLACE (city or town) (State or country)

*Baltimore, Maryland.*

10 NAME OF FATHER

*Arthur M. Cooper*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balto., Co., Md.*

12 MAIDEN NAME OF MOTHER

*Grace E. Hines*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore, Md.*

14

Informant

(Address)

*Anna R. Cooper**1416 Ramsay St.*

15

Filed

*Robert P. Barrett*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *January 27, 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*January 21, 1922, to January 27, 1922*that I last saw her alive on *January 26, 1922*and that death occurred, on the date stated above, at *8:15 A. m.*

The CAUSE OF DEATH\* was as follows:

*Broncho Pneumonia.*(duration) *0* yrs. *0* mos. *5* ds.

CONTRIBUTORY (Secondary)

*Choked*(duration) *0* yrs. *2* mos. *0* ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No.* Date ofWas there an autopsy? *No.*What test confirmed diagnosis? *None.*(Signed) *Henry F. Buettner*, M. D.19 (Address) *1273 William St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Louisa Park Cem.**Jan 30, 1922*

20 UNDERTAKER

ADDRESS

*Joseph B. Cook**1003 1/2 Balt. St.*

Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

JAN 27 1922

Serial Permit Clerk.

D 60714

HEALTH DEPARTMENT—CITY OF BALTIMORE

60714

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *411 Folsom*)ST.: *24* WARD:

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *William H Vogelmann Sr*(a) RESIDENCE. NO. *411 Folsom*  
(Usual place of abode)

ST.: WARD:

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *83* yrs. *9* mos. *15* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*5 Single, Married, Widowed,  
or Divorced (write the word)*Widowed*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Anne E Vogelmann*

6 DATE OF BIRTH (month, day, and year)

*April 11, 1858*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*63**9**15*

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Retired*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)*Police man*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Balto  
Maryland*

10 NAME OF FATHER

*Wm H. Vogelmann*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Germany*

12 MAIDEN NAME OF MOTHER

*Don't know*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Germany*

14

Informant

(Address)

*Charles W. Vogelmann  
1450 Covington st*

15

Filed

19

*Robert P. Harrison,*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Jan 26 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Nov 25, 1921, to Jan 26, 1922*that I last saw him alive on *Jan 25, 1922*and that death occurred, on the date stated above, at *12:15 a.m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*CONTRIBUTORY  
(Secondary)(duration) yrs. *2* mos. ds.(duration) yrs. *2* mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

*Funerally  
J. R. Campbell, M.D.**27, 1922 (Address) 1644 Hancock*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mount Olivet Cemetery**Jan 28 1922*

20 UNDERTAKER

ADDRESS

*John F. Denny**715 Light St*

N 27 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60715

## CERTIFICATE OF DEATH.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No.

ST.: 14 WARD

## 2-FULL NAME

(Residence in Baltimore: No.

St.: 30 yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Feb 14th 1836 (Month) (Day) (Year)

7-AGE, 85 yrs. 11 mos. 12 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work... None (b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE, (State or Country), North Carolina

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country), Not Carolina

12-MAIDEN NAME OF MOTHER, Caroline Wiley

13-BIRTHPLACE OF MOTHER (State or Country), North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo F Bragg, Jr

(Address) 1425 McCulloch St

15- Robert P. Harrless, Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan 26th 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1st 1922, to Jan 26th 1922, that I saw him alive on Jan 26th 1922, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(Duration) ... yrs. ... mos. ... ds.

## CONTRIBUTORY (Secondary)

Chronic Interstitial Nephritis

(Signed) Harry F Brown, M. D.

Jan 21, 1922 (Address) 1501 Presbiterian

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Fetersburg Rd

## DATE OF BURIAL,

Jan 28th 1922

## 20-UNDERTAKER

Sue L. W. W. W.

## ADDRESS

5780 Biddle

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

N 8 81922

191 Permit Clerk Registrar.



D 60716 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60716

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 3 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaiah Anderson or Howard Ball(a) RESIDENCE. NO. 1602 Eastern Ave.  
(Usual place of abode)ST. 3 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 years mos.

ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18857 AGE Years 36 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Michigan10 NAME OF FATHER Charlie Anderson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Michigan12 MAIDEN NAME OF MOTHER Eliza Miller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Michigan14 Informant Hospital Records  
(Address) M.T.H.15 Filed Robert P. Harrison,

Registrar

Deputy Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26, 1922

17

I HEREBY CERTIFY, That I attended deceased from  
Nov. 16, 1921, to Jan. 26, 1922.that I last saw him alive on Jan. 26, 1922.and that death occurred, on the date stated above, at 6.49 a. m.

The CAUSE OF DEATH\* was as follows:

Tuberculous Cervical, Mediastinal  
and post-Peritoneal adenitis.(duration) yrs. 5 mos. ds.CONTRIBUTORY Tuberculous sinuses, Hypo-  
(Secondary) cardial Insufficiency yrs. 5 mos. ds.18 Where was disease contracted  
If not at place of death? UnknownDid an operation precede death? Yes Date of Jan. 25, '22.Was there an autopsy? YesWhat test confirmed diagnosis? Quin-pig injection(Signed) Francis J. Dabaghi M. D.-26-22 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Edgely CemeteryJan 28 1922

20 UNDERTAKER

ADDRESS atEdward Byron1631 arden

N 881922

D 60717

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.: 36 yrs. mos. de.)

**MEDICAL CERTIFICATE OF DEATH.**

3-SEX.

4-COLOR OR RACE.

5-SINGLE,  
MARRIED, *Single*  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

C-DATE OF BIRTH.

(Month)

(Day)

(Year)

7-AGE.

Yr. .... mo. .... d.

**If LESS than 1 day,**

... hrn. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

•-BIRTHPLACE,  
(State or Country).

10-NAME OF  
FATHER.

**11-BIRTHPLACE  
OF FATHER  
(State or Country).**

12-MAIDEN NAME  
OF MOTHER

**13-BIRTHPLACE  
OF MOTHER  
(State or Country).**

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address

18-

Robert P. Harrison;

JOHN S HOPKINS HOSPITAL

## 20-UNDERTAKER

20-UNDERTAKER  
Commissioner Health;

ADDRESS

ADDRESS

Mr. Wm E. Woodall.

D 60718

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60718

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.: *4* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE, NO. *741 N. Lexington* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *56* yrs. *9* mos. *19* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Male**White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Apr 18, 1865*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*56**9**9*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Cement*

9 BIRTHPLACE (city or town) (State or country)

*Balto. Md.*

10 NAME OF FATHER

*Michael Kelly*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Md.*

12 MAIDEN NAME OF MOTHER

*Mary Waters*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Md.*

14

Informant (Address)

*Mercy Hospital Records*

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 27, 1922*

17

I HEREBY CERTIFY, that I attended deceased from

*Dec 30, 21, to Jan 27, 1922*that I last saw him alive on *Jan 27, 1922*and that death occurred, on the date stated above, at *11:30 P.M.*

The CAUSE OF DEATH\* was as follows:

*Scarlet Interstitial Nephritis*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *John H. Brown, M. D.*, 19 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Cathedral Jan 30, 1922*

20 UNDERTAKER

ADDRESS

*William Beck 302 E. Main*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

D 60719

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60719

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1514 John St. 14 WARD)

## 2-FULL NAME

Hermit R. Flautt

(Residence in Baltimore: No. 1514 John St.)

## REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

3 mos. 3 da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

male

## 4-COLOR OR RACE,

White

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

Single

## 6-DATE OF BIRTH,

Oct. 24, 1921  
(Month) (Day) (Year)

## 7-AGE,

3 mos. 3 da.

## If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Child

9-BIRTHPLACE,  
(State or Country),

Baltimore Md.

## 10-NAME OF FATHER,

Porter H. Flautt

11-BIRTHPLACE OF FATHER  
(State or Country)

Baltimore Md.

## 12-MAIDEN NAME OF MOTHER

Thelma Osterman

13-BIRTHPLACE OF MOTHER  
(State or Country),

Georgia

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Porter H. Flautt

(Address) 1514 John St.

## 15-

Filed

Robert R. Harrison,

Registrar.

Burial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan. 27, 1922  
(Month) (Day) (Year)

## 17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

opsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary) As. Bacter. Endocarditis

(Duration) yrs. mos. 3 da.

(Signed) J. T. Harrison, M. D.

(Coroner.)

(Address) 2802 E. Lombard St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, DATE OF BURIAL,

Northhampton Jan. 28, 1922

20-UNDERTAKER ADDRESS

William Beck 302 E. North



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60720

## CERTIFICATE OF DEATH.

D 60720

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO. *110 Scott*ST.: *18* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Catherine Krane*(a) RESIDENCE. NO. *110 Scott*

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *56* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 26 1844*

7 AGE

*78*

Years

Months

Days

If LESS than 1 day, hrs. or min.

*6**27*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *deat 18 now*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *deat 18 now*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*14 Informant (Address) *Mrs J. Lauer 680 Kilmar*15 Filed *Robert P. Harrison*

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 27 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan 1*, 19*22*, to *Jan 27*, 19*22*.that I last saw him alive on *Jan 26*, 19*22*.and that death occurred, on the date stated above, at *12* m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Harry Boyd*, M. D.1-27, 1922 (Address) *682 Columbia*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*London Park Cem Jan 30 1922*

20 UNDERTAKER

ADDRESS

*11111 of Ave 1 729 W Pratt*

JAN 28 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

D 60721

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60721

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

601 Richwood Ave

ST.

WARD)

## 2-FULL NAME

Sarah Francis Clark

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE. NO.

601 Richwood Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, (Widowed) or Divorced (write the word)

Widowed

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John E. Clark

## 6 DATE OF BIRTH (month, day, and year)

Mar - 1859

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

62

10

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

## 10 NAME OF FATHER

James Brown

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

## 12 MAIDEN NAME OF MOTHER

Sarah E Brown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

## 14

Informant (Address)

Daughters - Loretta

## 15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan 27 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan 1921, to Jan 27, 1922.

That I last saw him alive on Jan 27, 1922.

and that death occurred, on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Lique

(duration) 2 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Acute Perc. Nephritis

(duration) 1 yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 1920

Was there an autopsy? No

What test confirmed diagnosis?

Clinical

(Signed)

H. W. Wheaton, M. D.

, 19

(Address) 4235 York Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Kurbath Memorial 1-30-22

## 20 UNDERTAKER

## ADDRESS

J. J. Moran

E. Baltoff

B.—WRITE PLAINLY, WITH CAREFULNESS. PHYSICIANS SHOULD BE CAREFUL TO STATE EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

JAN 28 1922

## HEALTH DEPARTMENT - CITY OF BALTIMORE

D 60722

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *2308. Castle*)ST. *2* WARD

## 2. FULL NAME

(a) RESIDENCE NO. *230 S. Castle*

(Usual place of abode)

Length of residence in city or town where death occurred *50* yrs. mos. ds.ST. *2* WARD  
(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White Widowed*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

*Malissa Lynch*6 DATE OF BIRTH (month, day, and year) *Jan 26 1847*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*74*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Ireland*

10 NAME OF FATHER

*John Cahill*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ireland*

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

*John Cahill*

15

*Robert P. Harrison,*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan. 26 1922*17 I HEREBY CERTIFY, That I attended deceased from *Dec 12 1920* to *Jan 26 1922*that I last saw *her* alive on *Jan 25 1922*and that death occurred, on the date stated above, at *5:45* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Nephritis*(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) *2* yrs. mos. ds.18 Where was disease contracted if not at place of death? *no*Did an operation precede death? *no*Was there an autopsy? *no*What test confirmed diagnosis? *Symptoms*

(Signed)

1272

19

(Address)

*1937 7th*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

*New Cathedral*  
*J. A. Moran*

DATE OF BURIAL

*1/30 1922*

ADDRESS

*2000 E. Baltimore*

Exact statement of DEATH should be stated EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

1922

Burial Permit Clerk.

D 60723

## HEALTH DEPARTMENT—CITY OF BALTIMORE

B 60723

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

St. Agnes Hosp.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 25 WARD)

2-FULL NAME

Clifford P. Morrison

(a) RESIDENCE. NO.

603 Young St. Selma, Ala.

ST. WARD.

Selma Ala.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

Wh.

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Mrs. Anna H. Morrison

6 DATE OF BIRTH (month, day, and year)

Unknown, 1878

7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

51

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Revenue Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Ala.

(State or country)

10 NAME OF FATHER

Not Known

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Not Known

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Not Known

14

Informant (Address)

William L. McGill, Selma Ala.

15

Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 27, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 21, 1922, to Jan 27, 1922,

that I last saw him alive on Jan 27, 1922,

and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH\* was as follows:

Carcinoma Lip - Metastasis to glands of neck -

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Pneumonia

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Selma Ala.

Did an operation precede death?

yes, Date of 1-24-22

Was there an autopsy?

No

What test confirmed diagnosis?

Microscopic

(Signed)

W. G. Caldwell

M. D.

, 19 (Address)

St. Agnes Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Selma Ala.

Jan 28, 1922

20 UNDERTAKER

ADDRESS

Joseph B. Cook

1003 N. Calhoun

N 8 81922

Burial Permit Clerk.

maison should be carefully supervised. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



# HEALTH DEPARTMENT—CITY OF BALTIMORE **D 60724** **D 60724** CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 24 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Bergesen(a) RESIDENCE. No. 321 E. Fort Ave ST.     WARD.    

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 3 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofMargaret Bergesen6 DATE OF BIRTH (month, day, and year) 1887 Oct 6

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

34 3 20    

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,  
(State or country) Maryland10 NAME OF FATHER Henry Bergesen11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Norway12 MAIDEN NAME OF MOTHER Minnie Karmer13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Germany

## 14

Informant Hospital Records,  
(Address) Municipal Hospital.

## 15

Robert P. Harrison

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26 1922

17 I HEREBY CERTIFY, That I attended deceased from January 16, 1922 to January 26, 1922, that I last saw him alive on January 25, 1922, and that death occurred, on the date stated above, at 7:00 A.M.

The CAUSE OF DEATH\* was as follows:

Sarcoma of left leg - metastases to spine lungs & ribs -(duration) 5 yrs. mos. ds.CONTRIBUTORY  
(Secondary)Bronchial pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted —  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? yes

What test confirmed diagnosis?

(Signed)

Autopsy findings  
L. H. Brumback M. D.1/26/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Olm1/28/22

20 UNDERTAKER

ADDRESS

E. J. Fanning & Son 1938 Lafayette Ave

Information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

AN 81922

## HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 60725

## CERTIFICATE OF DEATH.

D 60725

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 13 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

## (a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

Leflore mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Henrietta Kraus

## 6 DATE OF BIRTH (month, day, and year)

April 28, 1855

## 7 AGE

Years

Months

Days

If LESS than

1 day. hrs.

or min.

66

9

4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Manufac

(b) General nature of industry, business, or establishment in which employed (or employer)

Cigars

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Balto, Md

## 10 NAME OF FATHER

Louis Kraus

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Betty Fleischman

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

## 14

Informant

(Address)

Mr Kraus

Emerson St

## 15

Filed

Robert P. Harrison,

19

Registrar

AN 2 8 1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan 27, 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jorway, 1921, to Jan. 27, 1922, that I last saw him alive on Jan. 26, 1922,

and that death occurred, on the date stated above, at 3:30 A. M.

The CAUSE OF DEATH\* was as follows:

Angina Pectoris

(duration) yrs. mos. 7 ds.

## CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. Wolman, M. D.

, 19 (Address) 2444 Fulton Place

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Har Sinai

Jan 30, 1922

## 20 UNDERTAKER

## ADDRESS

David Sondheim

111 W. W. R. Rd.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60726

## CERTIFICATE OF DEATH.

129 D 60726

1-PLACE OF DEATH US.V. HOSP. #56.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. FORT MCHENRY BALTO. MD. ST. 24 WARD)

2-FULL NAME JAMES B. HENSHEY

(a) RESIDENCE NO. US.V. HOSP. #56 FORTMCHENRY ST. BALTO. MD.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown/

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 63 yrs. --- ---

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work US. PHS. Attendant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland.

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

unknown

12 MAIDEN NAME OF MOTHER

unknown.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

unknown.

14

Informant E.T. Rosenbrock (Registrar)  
(Address) US. V. Hosp. #56 Balto. Md/

15

AN 28 1922

[Signature]

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN. 25, 1922

17

I HEREBY CERTIFY, That I attended deceased from JAN. 24, 1922, to JAN. 25, 1922, that I last saw him alive on JAN. 25, 1922, and that death occurred, on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH\* was as follows:

Nephritis chronic.

(duration) --- yrs. --- mo. --- da.

CONTRIBUTORY Uremia acute.  
(Secondary)

(duration) --- yrs. --- mo. --- da.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No.

What test confirmed diagnosis? Clinic report.

(Signed) J. N. Gordon, M. D.

19 (Address) Surgeon (R) US. V. Hosp. #56 Balto. Md

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

Westliberty Parkton Md. Jan 29 1922

20 UNDERTAKER

E. LeRoy Stiffler

ADDRESS

125 E. NORTH

D 60727

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60727

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2011 1/2 Lanvale ST. 16 WARD)

## 2. FULL NAME

(a) RESIDENCE No. 2011 1/2 Lanvale ST.

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

(If non-resident give city or town and State)

mos.

ds.

## MEDICAL CERTIFICATE OF DEATH

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced, HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

Robert F. Harrison, Registrar

Registrar

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, that I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Exact statement of occupation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

JAN 28 1922

Special Permit Clerk



D 60728

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60728

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 928 n Gay St. 10

ST. 10

WARD)

2-FULL NAME

Mary J. Ross

(Residence in Baltimore: No. 928 n Gay St.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. 3 ds.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE,

Col

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

File.

6-DATE OF BIRTH,

1862  
(Month) (Day) (Year)

7-AGE,

60

Yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).Domestic  
0709-BIRTHPLACE,  
(State or Country),

M.D.

10-NAME OF FATHER,

Denis B. Ross

11-BIRTHPLACE OF FATHER  
(State or Country),

M.D.

12-MAIDEN NAME OF MOTHER

Mary E. Brown

13-BIRTHPLACE OF MOTHER  
(State or Country),

M.D.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Anthony Ross

(Address).

928 n Gay St.

15-

Robert P. Harrison,

Filed

191

Serial Permit Clerk. Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Jan 25 1912  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held as

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.)

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Asphyxia probably Indur-

Culor

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Coroner.)

1-26-1912 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Atlantic City N.J.

19-PLACE OF BURIAL OR REMOVAL,

Ashbury Cemetery

DATE OF BURIAL,

Jan 28 1912

20-UNDERTAKER

ADDRESS

Charles Bailey 142 W. Jefferson St.

M.D. 1170

B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is important. See instructions on back of certificate.

JAN 28 1922

D 60729

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60729

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1153 Riverside* ST. *74* WARD)

## 2-FULL NAME

(a) RESIDENCE. NO. *1153 Riverside* ST. *74* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

AN 8 81922

REGISTRAR

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 27 1922*

17 I HEREBY CERTIFY, That I attended deceased from

*Jan 18 1922*, to *Jan 27 1922*,that I last saw her alive on *Jan 26 1922*,and that death occurred, on the date stated above, at *10 A. m.*

The CAUSE OF DEATH was as follows:

*Failure of Circulation Arteries to close*

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *W. L. Seabury* M. D.*1/28 1922* Address *638 Falk Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Forrain Cemetery**1/28 1922*

20 UNDERTAKER

ADDRESS

*W. L. Seabury & Sons 1318 E. Pratt St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60730

D 60730

## 1. PLACE OF DEATH

CITY OF BALTIMORE (No. 4117 West 24th St., 17th WARD)

## 2. FULL NAME

(a) RESIDENCE NO. 417 West 24th St., 17th WARD

(Usual place of abode)

Length of residence in city or town where death occurred

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, Divorced (write the word)

6 If married, widowed, or divorced

HUSBAND or WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

JAN 29 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## CERTIFICATE OF DEATH.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 15 1921 to Jan 27 1922 that I last saw him alive on Jan 27 1922

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Aortic Stenosis

CONTRIBUTORY (Secondary) (duration) 2 yrs. mos. ds. Gen Heart failure

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there a autopsy?

What test confirmed diagnosis? Ex. Physical

(Signed) E. J. Galt M. D.

19 (Address) 2413 Grand St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

5028 North

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. TION is very important.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60731

## CERTIFICATE OF DEATH.

REGISTERED NO.

D 60731

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal HospitalST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Abresch(a) RESIDENCE. NO. 1339 Gilmore St  
(Usual place of abode)

ST.,

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18517 AGE Years Months Days If LESS than 1 day, hrs. or min.  
70 -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia  
(State or country)10 NAME OF FATHER John Norton11 BIRTHPLACE OF FATHER (city or town) England  
(State or country)12 MAIDEN NAME OF MOTHER Sarah Hall13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)14 Informant Hospital Records,  
(Address) Municipal Hospital.15 Filed JAN 29 1922 ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26 19 2217 I HEREBY CERTIFY, That I attended deceased from January 26, 1922, to January 26, 1922.  
that I last saw her alive on January 26, 1922.  
and that death occurred, on the date stated above, at 7:30 P.M.  
The CAUSE OF DEATH\* was as follows:Atrophic Cirrhosis of liverCONTRIBUTORY (Secondary) Myocardial insufficiency  
(duration) 2 yrs. mos. ds.18 Where was disease contracted  
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? YesWhat test confirmed diagnosis? Autopsy  
(Signed) Chas. McNeil M. D.1/28/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL 1/30 19 2220 UNDERTAKER William Croft ADDRESS 502 E North St.

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION, CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60732

D 60732

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital

ST.: 10 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard M. Norris

(a) RESIDENCE. NO. 1418 E. Biddle St

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

Jan 4 1843

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

78

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## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carriage trimmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER Richard Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Hospital Records, Municipal Hospital.

15

Filed

JAN 29 1922

ROBERT H. KRAUTER,

Burial Permit Clerk.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26 1922

17

I HEREBY CERTIFY, That I attended deceased from January 19, 1922, to January 26, 1922, that I last saw him alive on January 26, 1922, and that death occurred, on the date stated above, at 9:40 P.M. The CAUSE OF DEATH\* was as follows:

Pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1/27/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery 1/30 1922

20 UNDERTAKER

ADDRESS

William Cook

502 E. North

Information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CO D A K S A F

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60733

## CERTIFICATE OF DEATH.

74 D 60733

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 N. Broadway ST., 8 WARD)

## 2. FULL NAME

Conrad Graf

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1721 N. Broadway ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower5a If married, widowed, or divorced HUSBAND of (or) Leah Graf6 DATE OF BIRTH (month, day, and year) April 14<sup>th</sup> 18357 AGE Years 86 Months 9 Days 13 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor + Builder(b) General nature of industry, business, or establishment in which employed (or employer) oil

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)10 NAME OF FATHER John Graf11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)14 Informant Charles C. Graf (Address) 1721 N. Broadway15 JAN 29 1922 ROBERT R. KRAUTER, Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27<sup>th</sup> 192217 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1922, to Jan 26, 1922, that I last saw him alive on Jan 26, 1922, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? m Date ofWas there an autopsy? m

What test confirmed diagnosis?

(Signed) Robert J. Green M. D.1-27, 1922 (Address) 1201 August 27

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park Cemetery

DATE OF BURIAL

Jan 30<sup>th</sup> 1922

20 UNDERTAKER

George Schilling + Sons

ADDRESS

1126 E Monument

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

411 2576-11 01c  
Spec.—8-24-14—M. & T.—2000 Bks.

D 60734

HEALTH DEPARTMENT—CITY OF BALTIMORE

VD 60734

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 236 N. Monmouth ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Robert Selby Burton  
(Residence in Baltimore: No. 226 N. Monmouth St.)

St.; 46 yrs., 4 mos., 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.  
(Write the word.)

Married

6-DATE OF BIRTH.

Aug. 1, 1875.  
(Month) (Day) (Year)

7-AGE.

46 yrs., 4 mos., 27 ds.

If LESS than 1 day,  
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Superintendent  
Walker-Gordon  
Laboratory 086

9-BIRTHPLACE.  
(State or Country).

Baltimore Md.

10-NAME OF FATHER.

Robert Burton

11-BIRTHPLACE OF FATHER.  
(State or Country).

Cambridge Md.

12-MAIDEN NAME OF MOTHER.

Mary C. Selby

13-BIRTHPLACE OF MOTHER.  
(State or Country).

Baltimore Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Mrs. Robert S. Burton

(Address).

Mrs. Robert S. Burton  
226 N. Monmouth St.

15-

JAN 29 1922

ROBERT R. KRAUTER,

Bureau Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

January 27, 1922.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 23, 1922, to Jan. 27, 1922, that I saw him alive on Jan. 27, 1922, and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH\* was as follows:

Cerebral Syncope

(Duration)....yrs....mos....ds.

CONTRIBUTORY  
(Secondary)

Heart Inflammation

(Duration)....yrs....mos....ds.

(Signed) H. H. Roberts, M. D.

Jan. 27, 1922 (Address) 219 N. Calhoun St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Wood Lawn Cemetery

DATE OF BURIAL.

Jan. 30, 1922

ADDRESS

108 Edmondson Ave

20-UNDERTAKER

Wilbur W. Shiver

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60735

REGISTERED NO.

D 60735

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl White(a) RESIDENCE. NO. 1505 Prentiss St. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? 1 yrs. 1 mos. 1 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

?

6 DATE OF BIRTH (month, day, and year) March 13/19177 AGE Years 3 Months 10 Days 13 If LESS than 1 day, 1 hr. or 1 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Chief 000

(b) General nature of industry, business, or establishment in which employed (or employer)

?

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)10 NAME OF FATHER Blanche11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)12 MAIDEN NAME OF MOTHER Willie White13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)14 Informant JOHNS HOPKINS HOSPITAL (Address)15 JAN 29 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-26 19 2217 I HEREBY CERTIFY, That I attended deceased from 12-24, 1921, to 1-26-22, 1922that I last saw him alive on 1-26, 1922and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis, pulmonary  
(Cavitation)(duration) unknown yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) unknown yrs. 1 mos. 1 ds.18 Where was disease contracted if not at place of death? HomeDid an operation precede death? no Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Tuberculin + Tray(Signed) Thos Balling Gay, M. D., 19 (Address) Johns Hopkins Hosp N 614

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Air Farm Cem. Jan 30 1922

20 UNDERTAKER

ADDRESS

Samuel Hensley 678 W. Biddle

Information should be carefully supplied. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

60736

10 D 60736

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. JOHNS HOPKINS HOSPITAL ST.: 8 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Amuel Jones(a) RESIDENCE. No. 1611 St. Joseph St

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 28 ds.How long in U. S., if of foreign birth? 2 yrs. 2 mos. 28 ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Black

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Oct. 30<sup>th</sup> 1915

## 7 AGE

Years

Months

Days

If LESS than 1 day, 28 hrs. or 2 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

BaltimoreMaryland

## 10 NAME OF FATHER

Geo. Jones

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Va.

## 12 MAIDEN NAME OF MOTHER

Ratie Johnson

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Va.

## 14

Informant

(Address)

## 15

JAN 29 1922ROBERT H. KRAUTERBurial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan 29<sup>th</sup> 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan. 1<sup>st</sup> 1922, 1922, to Jan 29<sup>th</sup> 1922, 1922,that I last saw him alive on Jan. 28<sup>th</sup> 1922, 1922,and that death occurred, on the date stated above, at 12:40 P.M.

The CAUSE OF DEATH\* was as follows:

Diphtheria - 10 days following operation for old congenital due to polio infection in 1916(duration) 16 yrs. 10 mos. 10 ds.

## CONTRIBUTORY (Secondary)

Myocarditis acute(duration) 10 yrs. 10 mos. 10 ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of Jan 5 1922Was there an autopsy? NoWhat test confirmed diagnosis? Throat cultures.(Signed) R. H. Krauter, M. D., 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Laurel Ceme. Jan. 28<sup>th</sup> 1922

## 20 UNDERTAKER

## ADDRESS

Mrs. G. G. Locks 1200 Jefferson

mation should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 60737

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 19 WARD)

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

JAN 29 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 28, 1922, to Jan 28, 1922,

that I last saw him alive on Jan 28, 1922,

and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma stomach with perforation and localized peritonitis -

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 10 ds.

18 Where was disease contracted

If not at place of death? Fayetteville W. Va.

Did an operation precede death? No Date of -

Was there an autopsy? Yes

What test confirmed diagnosis? Post mortem exam

(Signed) E. Coates Andrews, M. D.

19 (Address) Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Thurmond West 80 Jan 29 1922

20 UNDERTAKER

ADDRESS

Joseph Andrews 226 Bury

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1012 Scott*)ST.: *21* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *George H. Scharf*(a) RESIDENCE. NO. *1012 Scott*  
(Usual place of abode)

ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? *69* yrs. *9* mos. *16* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Eleanora Scharf*6 DATE OF BIRTH (month, day, and year) *April 11<sup>th</sup> 1852*7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*69* *9* *16*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Boiler Maker*(b) General nature of industry, business, or establishment in which employed (or employer) *Retired* *086*

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md.*  
(State or country)10 NAME OF FATHER *William J. Scharf*11 BIRTHPLACE OF FATHER (city or town) *Baltimore Md.*  
(State or country)12 MAIDEN NAME OF MOTHER *Martina A. Joyner*13 BIRTHPLACE OF MOTHER (city or town) *St. Louis Mo.*  
(State or country)14 Informant *Eleanora Scharf*  
(Address) *1012 Scott St.*15 *JAN 30 1922* ROBERT H. KRAUTER  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan. 27<sup>th</sup> 1922*17 I HEREBY CERTIFY, that I attended deceased from *Aug 24<sup>th</sup> 1919* to *Jan 27<sup>th</sup> 1922*that I last saw him alive on *Jan 26<sup>th</sup> 1922*and that death occurred, on the date stated above, at *9:55 A. M.*

The CAUSE OF DEATH\* was as follows:

*Exhaustion*CONTRIBUTORY *Chronic Pulmonary*  
(duration) *3* yrs. *7* mos. *7* ds.*nephritis* (duration) *3* yrs. *7* mos. *7* ds.18 Where was disease contracted  
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. P. Burton* M. D.(Address) *654 Columbia Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Loudon Park Cemetery* *Jan 30<sup>th</sup> 1922*

20 UNDERTAKER

ADDRESS

*Mrs. John H. Tengel & Son* *801 N. Fayette*

60739  
D 60739

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-0  
D 60739

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 Kantiske

ST.: 21 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Hainke

(a) RESIDENCE. No. 1120 Kantiske

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? 58 yrs. 10 mos. 20 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mollie Hainke

6 DATE OF BIRTH (month, day, and year)

March 6, 1863

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

58

10

20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Machinist Helper

(b) General nature of industry, business, or establishment in which employed (or employer)

Baltimore Tube Co

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Baltimore Md

## 10 NAME OF FATHER

August Hainke

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

## 14

Informant

Mollie Hainke

(Address)

1120 Kantiske St.

## 15

JAN 30 1922

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan. 26, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 23, 1922, to Jan 26, 1922

that I last saw him alive on Jan 20, 1922

and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

## CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyd M. D.

1-27 19 21 (Address)

621 Columbia

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

London Park Cemetery

Jan 30 1922

## 20 UNDERTAKER

## ADDRESS

Mr. Mrs. John W. Tempel &amp; Son 801 N. Fayette

mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



60740  
D 60740

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1720 Homestead St.;

WARD) 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Joseph A. Baker

## (a) RESIDENCE.

Maple Lake Farm, Catonsville

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

white

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Daisy Baker

## 6 DATE OF BIRTH (month, day, and year)

Oct 12, 1891

## 7 AGE

30

3

15

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Langier Is. Va.

## 10 NAME OF FATHER

Jos. A. Baker

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Del.

## 12 MAIDEN NAME OF MOTHER

Ella Connoiton

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

## 14

Informant

(Address)

Daisy Baker  
Maple Lake Farm - Catonsville

## 15

Filed

19

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan 27 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan 20<sup>th</sup>, 1922, to Jan 27, 1922,

that I last saw him alive on Jan 27, 1922,

and that death occurred, on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 9

(duration) yrs. mos. ds. 1

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. E. Smith, M. D.

, 19 (Address) 118 1/2 Calhoun St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Western Cem.

## DATE OF BURIAL

Jan 31<sup>st</sup> 1922

## 20 UNDERTAKER

Mr. Mrs. John W. Tenzel &amp; Son

## ADDRESS

801 N. Fayette St.

JAN 30 1922

tion should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

60741

D 60741

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 16 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 827 Whatecoat ST. 16 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of Samuel Sheppard (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 10<sup>th</sup> 1893

7 AGE Years 28 Months 9 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Washwoman

(b) General nature of industry, business, or establishment in which employed (or employer) OH

(c) Name of employer

9 BIRTHPLACE (city or town) Delaware (State or country)

10 NAME OF FATHER George Shump

11 BIRTHPLACE OF FATHER (city or town) Delaware (State or country)

12 MAIDEN NAME OF MOTHER Bessie Bulcher

13 BIRTHPLACE OF MOTHER (city or town) Delaware (State or country)

14 Informant Paula Dennis (Address) 1313 Crescent St

15 File JAN 3 01922 Registrar ROBERT H. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 19 22

17 I HEREBY CERTIFY, That I attended deceased from Jan 25 19 22 to Jan 27 19 22 that I last saw her alive on Jan 27 19 22 and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH\* was as follows: Acute. Cor. P. pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY Acute Cor. P. pneumonia (Secondary) pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted Home if not at place of death?

Did an operation precede death? Yes Date of Jan 25-22

Was there an autopsy? No

What test confirmed diagnosis? Phys. Signs

(Signed) Dr. J. J. Dennis M. D.

. 19 (Address) Mercy Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Auburn Cemetery Jan 31 19 22

20 UNDERTAKER ADDRESS 1313

Paula Dennis Crescent St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1461 Parrish*)

## 2-FULL NAME

(Residence in Baltimore: No. *1461 Parrish*)

REGISTERED NO. C

ST.: *15* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: *75* yrs., *—* mos., *—* da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE,

*Colored*

## 5-SINGLE,

MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)*Widow*

## 6-DATE OF BIRTH,

*Not Known**1842*

(Month)

(Day)

(Year)

## 7-AGE

*80**—**—**—**—**—**—**—**—**—**—**—*

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

*Domestic**070*

## 9-BIRTHPLACE,

(State or Country),

*Va*

## 10-NAME OF

FATHER,

*Anna Lively*

## 11-BIRTHPLACE

OF FATHER  
(State or Country),*Va*

## 12-MAIDEN NAME

OF MOTHER

*Maria Johnson*

## 13-BIRTHPLACE

OF MOTHER  
(State or Country),*Va*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

*Alta Galt**616 Baker St*

## 15-

ROBERT R. KRAUTER,

## File

No. *3**01922*

Bureau of

Records

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan 28<sup>th</sup> 1922*

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Dec 21<sup>st</sup> 1921* to *Jan 28<sup>th</sup> 1922*that I saw him alive on *Jan 26<sup>th</sup> 1922*and that death occurred, on the date stated above, at *9 A. m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage**not known**not known**not known**not known**not known**not known**not known**not known**not known**not known**not known**not known**not known**not known**not known*

N. B.—Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

60743

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

D 60743

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Emma Hawkins

(a) RESIDENCE. NO.

1337 Westport

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 20, 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

8

29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

John

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Margaret Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

File

JAN 3 0 1922

ROBERT R. KRAUTER,  
JAN 3 0 1922  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan. 28, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 17, 1922, to Jan. 28, 1922

that I last saw him alive on Jan. 28, 1922

and that death occurred, on the date stated above, at 9:05 P. M.

The CAUSE OF DEATH was as follows:

Tuberculosis Pulmonary

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

Generalized Miliary Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? house

Did an operation precede death? yes Date of 1/18/22

Was there an autopsy? yes

What test confirmed diagnosis? Sputum examination

(Signed) Horace G. Stevart, M. D.

1/18, 1922 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn Cemetery Jan. 31, 1922

20 UNDERTAKER

ADDRESS 1303

Paul A. Dennis

Crestwood

ation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



D 60744 HEALTH DEPARTMENT—CITY OF BALTIMORE 60744

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 639 N. Castle ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE, No. 639 N. Castle St.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 27 - 1922

7 AGE

Years

Months

Days

If LESS than 1 day, 12 hrs. or min.

1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt., Md.

10 NAME OF FATHER

Joseph Clay Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt., Md.

12 MAIDEN NAME OF MOTHER

Cruse

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt., Md.

14

Informant (Address)

Dr. C. Evans 639 N. Castle St.

JAN 30 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 28th 1922

17

I HEREBY CERTIFY, that I attended deceased from Jan. 27, 1922, to Jan 28, 1922, that I last saw him alive on Jan. 27, 1922.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Premature Birth.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Louis A. M. Krause

, 19

(Address) 2500 E. Madison

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Olivet Cemetery Jan 30 1922

20 UNDERTAKER

ADDRESS

Miss A. C. Miller 2537 Jefferson

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 60745

Spec. 100-10 P. Co. - 1000 Bks.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60745

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2642 Barnard St. ST.: 12 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. #2642 Barnard St. WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 48 yrs. How long in U. S., if of foreign birth life yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Louis Ripley6 DATE OF BIRTH (month, day, and year) Aug. 2/18707 AGE 51 Years 5 Months 26 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Woodstock (State or country) Ind.10 NAME OF FATHER Jefferson Smallwood11 BIRTHPLACE OF FATHER (city or town) Ind. (State or country)12 MAIDEN NAME OF MOTHER Mary J. Clark13 BIRTHPLACE OF MOTHER (city or town) Ind. (State or country)14 Informant Bertha A. Lockyer (Address) 350-1 Falls Road

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 192217 I HEREBY CERTIFY, that I attended deceased from Jan 10 1921 to Jan 28 1922 that I last saw him or her alive on Jan 28 1922 and that death occurred, on the date stated above, at 8:05 A. m. The CAUSE OF DEATH\* was as follows:Exhaustion

CONTRIBUTORY (Secondary)

Uterus (duration) yrs. mos. ds. few

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Richard D. M. D.19 (Address) 112 U. 20-45

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

M. Mary Haupten Jan 31 1922

20 UNDERTAKER

Walter Davis ADDRESS 3307

ROBERT R. KRAUTER, Registrar

JAN 30 1922

Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

D 60746

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60746

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

REGISTERED NO. C

## 2-FULL NAME

(Residence in Baltimore: No.

St.: yrs. mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

## 4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

## 6-DATE OF BIRTH

## 7-AGE

If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....

## 9-BIRTHPLACE, (State or Country),

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER (State or Country),

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER (State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

Filed

191

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH\* was as follows:

## CONTRIBUTORY (Secondary)

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

## 20-UNDERTAKER

## ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHISICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 60747

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60747

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1256 Hargrave ST. 9 WARD)

## 2-FULL NAME

Charles Heisterman

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofSarah Heisterman

## 6 DATE OF BIRTH (month, day, and year)

Oct. 15-1856

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.65412

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workRetired013(b) General nature of industry,  
business, or establishment in  
which employed (or employer)Butcher

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Balt

## 10 NAME OF FATHER

Charles Heisterman11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Balt.

## 12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Balt

## 14

Informant  
(Address)Sarah Heisterman  
1256 Hargrave Lane

## 15

Filed

19

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

1/27 1922

## 17

I HEREBY CERTIFY, That I attended deceased from  
1/1, 1922, to 1/27, 1922that I last saw him alive on 1/26, 1922and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH\* was as follows:

Gastric Carcinoma  
(Greater curvature)  
(duration) 2 yrs.CONTRIBUTORY  
(Secondary)Intestinal Obstruction  
(duration) 3 mos.18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? usual

(Signed)

J. Stanley Gough M. D.

19

(Address)

2700 1st St\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVALLandon Park Cemetery

## DATE OF BURIAL

Jan. 27 1922

## 20 UNDERTAKER

George J. Ruth 1735 Hayford  
an.

N. B. - WRITE PLAINLY, WITH CORRECTION. PHYSICIANS should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



D 60748 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60748

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1515 N. Fulton Ave. ST. 13 WARD)

## 2-FULL NAME

Geo. L. Albutt

## REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 3005 Pennsylvania Ave. 50 St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

male white

## 4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

## 6-DATE OF BIRTH,

May 20, 1854 (Month) (Day) (Year)

## 7-AGE,

68 yrs. 8 mos. 4 ds.

If LESS than 1 day, hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

Minister 018

## 9-BIRTHPLACE,

(State or Country),

England

## 10-NAME OF FATHER,

Geo. L. Albutt

## 11-BIRTHPLACE OF FATHER,

(State or Country),

England

## 12-MAIDEN NAME OF MOTHER,

Edna M. Brooks

## 13-BIRTHPLACE OF MOTHER,

(State or Country),

England

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Julia Albutt

(Address),

3005 Pennsylvania Ave.

## 15-

JAN 30 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan. 28, 1922 (Month) (Day) (Year)

## 17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

opsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Nephritis, heart disease

(Duration) / yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) / yrs. mos. ds.

(Signed) J. T. Hemmerson, M. D.

Jan 30, 1922 (Address) 202 E. ...

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Linden Park Jan. 31, 1922

20-UNDERTAKER ADDRESS

Joseph Super 1000 W. North

D 60749

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 D 60749

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 N Pine)ST. 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Jesse(Residence in Baltimore: No. 511 N Pine)St. 19 yrs. 1 mos. 1 da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M 4-COLOR OR RACE, Colum 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single6-DATE OF BIRTH, Jan 15, 1903  
(Month) (Day) (Year)7-AGE, 19 yrs. 27 mos. 27 da. If LESS than 1 day, ...hrs. or...min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. Labour  
(b) General nature of industry, business, or establishment in which employed (or employer). 0409-BIRTHPLACE, (State or Country), Baltimore Md10-NAME OF FATHER, Paul Jesse11-BIRTHPLACE OF FATHER (State or Country), Va12-MAIDEN NAME OF MOTHER Lizzie Dinger13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul Jesse(Address) 511 N Pine

15-

JAN 30 1922 191. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH, Jan 28, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Dec 19 1921, to Jan 28 1922, that I saw him alive on Jan 27 1922, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH\* was as follows:

tuberculosis of lung  
(Duration) 0 yrs. 9 mos. 1 da.CONTRIBUTORY (Secondary) none(Duration) 0 yrs. 9 mos. 1 da.(Signed) R. B. Dinger M. D.Jan 28, 1922 (Address) 109 W. 7th St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 0 da. In the State 0 yrs. 0 mos. 0 da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Ambrose DATE OF BURIAL, Jan 30, 1922.20-UNDERTAKER James T. Dinger ADDRESS 578 E. 1st St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 60750

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 Meyer St

ST.: 6 WARD)

## 2-FULL NAME

Andrew Garrett

## (a) RESIDENCE. NO. 1700 Meyer

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 11 mos. 21 ds.

ST.: WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Blk

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 11 1917

7 AGE

4

Years

Months

11

Days

25

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

JAN 30 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/27th 1922

17 I HEREBY CERTIFY, That I attended deceased from 1/22nd 1922, to 1/27th 1922,

that I last saw him alive on 1/27th 1922, and that death occurred, on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH\* was as follows:

Pyelo Nephritis

CONTRIBUTORY (Secondary)

Leptospirosis

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) Gustav Goldman M. D.

19 (Address) 1515 W. Franklin

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Not cremated

DATE OF BURIAL

Jan 30 1922

20 UNDERTAKER

Samuel Herschberg

ADDRESS

578 W. Biddle St

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-  
TION is very important. See instructions on back of certificates.





N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state  
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state  
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-  
TION is very important. See instructions on back of certificates.

D-60752-1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Joseph's Hospital*)

ST. *9* WARD

2-FULL NAME

(a) RESIDENCE. NO. *St. Joseph's Hospital*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *4* yrs. — mos. — ds.

How long in U. S., if of foreign birth? *4* yrs. — mos. — ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *not known*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *66*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *N. Y.*

10 NAME OF FATHER *Not known*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Not known*

12 MAIDEN NAME OF MOTHER *Not known*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Not known*

14 Informant *Records at St. Joseph's Hospital* (Address) *Caroline Oliver*

15 Filed *JAN 30 1922* 19 *ROBERT R. KRAUTER, Registrar* Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 27 1922*

17 I HEREBY CERTIFY, That I attended deceased from *January 27, 1922* that I last saw him alive on *January 27, 1922* and that death occurred, on the date stated above, at *9:15 P.M.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Apoplexy.*

CONTRIBUTORY (Secondary) *Chronic Nephritis & Arteriosclerosis* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date *Jan 25, 1922*

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *J. C. Marino*, M. D.

, 19 (Address) *St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Holy Redeemer Cemetery* *Jan. 31 1922*

20 UNDERTAKER

*Wm. H. Hock Inc* ADDRESS *1301 E. Eager St.*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60753

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-001  
D 60753

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph Hospital* ST. *10* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *1009 Aisquith*

ST. *10* WARD.

(Usual place of abode) Length of residence in city or town where death occurred *64* yrs. *2* mos. *20* ds. How long in U. S., if of foreign birth? *Life* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of *Theresa Soan* (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Nov. 8, 1857*

7 AGE Years *64* Months *2* Days *20* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Md.*

10 NAME OF FATHER *James R. Soan*

11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country) *Md.*

12 MAIDEN NAME OF MOTHER *Not Known*

13 BIRTHPLACE OF MOTHER (city or town) *Not Known* (State or country)

14 Informant *Mrs. Theresa Soan* (Address) *1009 Aisquith*

15 Filed *JAN 30 1922* ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan. 28, 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Jan. 27, 1922*, to *Jan. 28, 1922*, that I last saw him alive on *Jan. 28, 1922*, and that death occurred, on the date stated above, at *11.15 a.m.*

The CAUSE OF DEATH\* was as follows:

*Strangulated complete left inguinal hernia*

(duration) yrs. mos. *2* ds.

CONTRIBUTORY *Cardiac failure* (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *Jan. 27, 1922*

Was there an autopsy? *no*

What test confirmed diagnosis? *St. Joseph's Hosp.* (Signed) *J. R. Conte, Jr.* M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Holy Redeemer Cemetery* DATE OF BURIAL *Jan 31* 19 *22*

20 UNDERTAKER *Henry Wood, Son* ADDRESS *1301 E. Bay St.*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60754

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60754

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 W. Hoffman ST. 11 WARD)

2-FULL NAME

(a) RESIDENCE. No. 312 W. Hoffman ST. 11 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of

James Resk

6 DATE OF BIRTH (month, day, and year)

Month 14, 1869

7 AGE

52

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Self, Virginia

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15

JAN 3 0 1862

ROBERT E. KRAUTER, Registrar

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 25, 1921, to Jan 27, 1922, that I last saw him alive on Jan 26, 1922, and that death occurred, on the date stated above, at 2.50 A. M.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage.

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William H. Hughes, M. D.

(Address) 1209 Chestnut

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60755

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

31 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD.

(If nonresident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Richard Lynch  
Louise

6 DATE OF BIRTH (month, day, and year)

Aug 7 - 1890

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

Wholesale Store Nat.

(c) Name of employer

Douglas Grace Co.

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

J. P. Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Indo

12 MAIDEN NAME OF MOTHER

Mary Gierly

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Indo

14

Informant (Address)

Mrs. Richard Lynch  
3124 Windsor Ave.

15

Filed

JAN 30 1922

ROBERT H. KRAUTER,

Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 29 1922

17

I HEREBY CERTIFY, That I attended deceased from

1/20 1922, to 1/29 1922.

that I last saw him alive on

1/29 1922.

and that death occurred, on the date stated above, at

4 P. M.

The CAUSE OF DEATH\* was as follows:

Gastric ulcer - gastric  
Hemorrhage -

(duration) yrs. mos. 9 da.

CONTRIBUTORY (Secondary)

Cardiac decompensation

(duration) yrs. mos. 5 da.

18 Where was disease contracted If not at place of death?

3124 Windsor Ave.

Did an operation precede death?

yes Date of 1/26/22

Was there an autopsy?

no

What test confirmed diagnosis?

clinical

(Signed)

W. D. Dwyer, M. D.

. 19 (Address)

Maryland General Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral Cove

DATE OF BURIAL

Feb 1 1922

20 UNDERTAKER

Henry A. Jenkins & Sons

ADDRESS

McCallum

Richard



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Nonmalignant*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60756 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167 D 60756

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland General Hospital* ST. *13* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Baby Seaton*

(a) RESIDENCE. NO. *2667 Pennsylvania Ave.* (Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Single*

6 DATE OF BIRTH (month, day, and year) *Jan 24, 1922*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *4*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.* (State or country)

10 NAME OF FATHER *Clarence H. Seaton*

11 BIRTHPLACE OF FATHER (city or town) *Virginia* (State or country)

12 MAIDEN NAME OF MOTHER *Maria Rudolph*

13 BIRTHPLACE OF MOTHER (city or town) *Baltimore, Md.* (State or country)

14 Informant *Clarence H. Seaton* (Address) *2667 Pennsylvania Ave.*

15 *JAN 30 1922* ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 28 1922*

17 I HEREBY CERTIFY, that I attended deceased from *Jan 24 1922* to *Jan 28 1922*, that I last saw her alive on *Jan 28 1922*, and that death occurred, on the date stated above, at *2 a.m.*

The CAUSE OF DEATH\* was as follows:

*Congenital atelectasis*

(duration) yrs. mos. *4* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Stanley Matthews, M.D.*

19 (Address) *Maryland General Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Olmest Cem.* *Jan 30 1922*

20 UNDERTAKER

ADDRESS

*Martin Hakey, Son* *1827 W. N.*

D 60757 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 D 60757  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2327 N. Calvert

ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Weathermer M. C. Cuthrie

(Residence in Baltimore: No. 2327 N. Calvert St

St.: 5 yrs. mos. ds)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female  
4-COLOR OR RACE, White  
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

## 6-DATE OF BIRTH,

1898  
(Month) (Day) (Year)

## 7-AGE,

75 yrs. mos. ds.

If LESS than 1 day.

...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

None

## 9-BIRTHPLACE, (State or Country)

Ireland

## 10-NAME OF FATHER,

Thomas Tunney

## 11-BIRTHPLACE OF FATHER (State or Country)

Ireland

## 12-MAIDEN NAME OF MOTHER

Margaret Tunney

## 13-BIRTHPLACE OF MOTHER (State or Country)

Ireland

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Margaret M. Cuthrie

(Address)

2327 N. Calvert St.

## 15-

Filed

191

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

January 28, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

March 5 1921 to Jan 28 1922

that I saw him alive on January 27 1922

and that death occurred, on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH\* was as follows:

Heart & Mitral Insuff.  
Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Auto Intoxication of Heart

(Duration) yrs. mos. ds.

(Signed) G. H. Bishop M. D.

Jan 28, 1922 (Address) 581 Sheridan Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

St Marys German

## DATE OF BURIAL,

Jan 31, 1922

## 20-UNDERTAKER

Martin Kahyrols

## ADDRESS

1827 N. North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—PHYSICIANS should state EXACTLY, AGE, should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 MA? 1500 Hks.

D 60758

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60758

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Church Home & Infirmary,*

CITY OF BALTIMORE: (No. ....)

ST. *15* WARD)

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Miss Molly Coleman*

(a) RESIDENCE NO. *1800 Warwick ave* ST. ....

WARD ....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. .... mos. .... ds. How long in U. S., if of foreign birth? yrs. .... mos. .... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug 01 - 1863*

7 AGE Years Months Days If LESS than 1 day, hrs or min. *58 4 28*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *unknown*

(b) General nature of industry, business, or establishment in which employed (or employer) *087*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Maryland*

10 NAME OF FATHER *Wm W Coleman*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md*

12 MAIDEN NAME OF MOTHER *Anna Barringer*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md*

14 Informant *William Coleman* (Address) *1800 Warwick ave*

15 *JAN 3 0 1922*

ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *1/28/1922*

17

I HEREBY CERTIFY, That I attended deceased from *1/10*, 1922, to *1/28*, 1922, that I last saw *her* alive on *1/28*, 1922, and that death occurred, on the date stated above, at *1:30 P. m.* The CAUSE OF DEATH\* was as follows: *Pulmonary Embolism*

CONTRIBUTORY (Secondary)

(duration) yrs. .... mos. .... ds. *18 hrs.*

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *Yes* Date of *1/11/22*

Was there an autopsy? *Yes*

What test confirmed diagnosis? *Autopsy*

(Signed) *A. B. Hughes* M. D.

*128* 1922 (Address) *Church Home & Inf.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Woodlawn Cemetery*

*Jan 31 1922*

20 UNDERTAKER

ADDRESS

*John Syfer*

*1600 W. North*





## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60760

D 60760

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

JAN 30 1922

ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

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(name origin; "Cancer" is less definite; avoid use of  
"Tumor" for malignant neoplasms); Measles;

*Affidavit*

Baltimore, Md., March 7, 1922.

I do hereby make oath that the name of deceased given on Baltimore City Health Department Certificate of Death - D-60760 as Joseph Harris is not correct, same should be recorded as Joseph Robert Schuler; also the name given of the father - Harry Harris is also incorrect; same should be recorded as Harry Leo Schuler.

*Harry Leo Schuler*  
Father.

*Leonora M. Schuler*  
Mother

Subscribed and sworn to before me this 7th day of March, 1922

*Red Barber*  
Notary Public.

MAR 7- 1922

*George H. Grease*  
Registrar's Clerk

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N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21 M&T—1500 Bks.

D 60761

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 60761

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 3509 Roland Ave. ST. 13 WARD)

2. FULL NAME

John H. Ebbert

(a) RESIDENCE No. 3509 Roland Ave. ST. 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marion E. Ebbert

6 DATE OF BIRTH (month, day, and year) July 4-1852

7 AGE Years 69 Months 6 Days 24 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marble Cutter 076

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 20 years.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Co. Maryland (State or country)

10 NAME OF FATHER Frederick Ebbert

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mrs. Eugene Baker (Address) 3509 Roland Ave.

15 ROBERT H. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1921, to Jan 28, 1922.

that I last saw him alive on Jan 28, 1922, and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH\* was as follows:

Metastatic carcinoma of the prostate gland.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Biopsy of prostate

(Signed) E. H. Kelly, M. D.

(Address) 3105 2nd St. N. W.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Woodlawn Cemetery

DATE OF BURIAL Jan 30 1922

ADDRESS

Horace H. Burge 3631 Falls Rd.



D 60762

HEALTH DEPARTMENT—CITY OF BALTIMORE 60762

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. 15 N. 13th St. HARRISBURG PA

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant: (Address)

15

JAN 3 0 1922

ROBERT R. KRABIER

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 27th, 1922, to Jan. 30th, 1922,

that I last saw him alive on Jan. 30th, 1922,

and that death occurred, on the date stated above, at 12:25 P.M.

The CAUSE OF DEATH\* was as follows:

BACTERIAL ENDOCARDITIS (STREP VIRIDANS)

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? BLOOD CULTURE

(Signed) John L. Dorsey, M. D.

, 19 (Address) L.H.H.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60763

## CERTIFICATE OF DEATH.

X 47 D 60763

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Howard A. Kelly Hospital* ST. *WARD*)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Mrs. William Samuel Powell*

## (a) RESIDENCE. NO.

*Rural Hall, North Carolina.* ST. *WARD.*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

19

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Married*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Mr. William S. Powell.*

## 6 DATE OF BIRTH (month, day, and year)

*Aug 6-1868*

## 7 AGE

Years

Months

Days

*53**6**24*

If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

*037*

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Amelia Court House, Virginia*

## 10 NAME OF FATHER

*Mr. H. D. Knight*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Gadsden, Va.*

## 12 MAIDEN NAME OF MOTHER

*Mrs. W. Knight*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant (Address)

*Mrs. Nellie Zimmerman, Rural Hall, N.C.*

## 15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*Jan 30 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*Jan. 11, 1922, to Jan. 30, 1922,*that I last saw her alive on *Jan. 30, 1922,*and that death occurred, on the date stated above, at *7 24 a.m.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of breast.*(duration) \_\_\_\_ yrs. *15* mos. \_\_\_\_ ds.

## CONTRIBUTORY (Secondary)

*Diabetes, High blood pressure*  
(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *Jan. 17, 1922*Was there an autopsy? *No*What test confirmed diagnosis? *Microscopic exam. of tissue*(Signed) *Robert E. Fricker*, M. D.19 (Address) *1428 Canton Place*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Greensboro North Carolina Jan 30 1922*

## 20 UNDERTAKER

## ADDRESS

*Chas. G. Black 742 W. North Ave*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

JAN 30 1922

D 60764

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60764

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *309 Parrish* ST.: *19* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *309 Parrish* St.: *19* yrs. *1* mos. *9* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Male*

## 4-COLOR OR RACE

*White*

## 5-SINGLE,

*Single*

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

## 6-DATE OF BIRTH,

*Dec 17, 1916*  
(Month) (Day) (Year)

## 7-AGE,

*6* yrs. *1* mos. *9* ds.

If LESS than 1 day,

....hrs. or ....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,  
(State or Country),

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER

(State or Country),

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER

(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

## 15-

Filed..... 191.....

Registrar.....

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan 26, 1917*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Jan 26, 1917, to Jan 26, 1917*that I saw him alive on *Jan 26, 1917*and that death occurred, on the date stated above, at *11:58* m.

The CAUSE OF DEATH\* was as follows:

*Bronchopneumonia.*  
(Duration)..... yrs. .... mos. .... ds.CONTRIBUTORY  
(Secondary)*Acute Bronchitis*  
(Duration)..... yrs. .... mos. .... ds.

(Signed)..... M. D.

*Jan 26, 1917* (Address).....

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Western Cemetery**Jan 30, 1917*

## 20-UNDERTAKER

## ADDRESS

*Harry H. Witzke**1314 N. Bond*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 30 1917

60765

## HEALTH DEPARTMENT—CITY OF BALTIMORE

60765

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST.: 9

## REGISTERED NO.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Harry Ferembach

## (a) RESIDENCE. NO.

342 E. 29th St.

ST.

WARD.

Patterson, N.J.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

5 yrs. 5 mos. 5 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofBrooklyn S. Ferembach

## 6 DATE OF BIRTH (month, day, and year)

Dec. 19, 1877

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.44130

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Silk dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

04

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)New Jersey

## 10 NAME OF FATHER

Gregory Ferembach11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Scotland

## 12 MAIDEN NAME OF MOTHER

Marta Cushman13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)N.J.

## 14

Informant  
(Address)JOHNS HOPKINS HOSPITAL

## 15

Filed

19

JAN 30 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan. 30, 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan. 17, 1922 to Jan. 30, 1922that I last saw him alive on Jan. 30, 1922and that death occurred, on the date stated above, at 6:15 A.M.

The CAUSE OF DEATH\* was as follows:

Acute peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)Urteral structure (left)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

Place of death

## Did an operation precede death?

YesDate of Jan 25, 1922

## Was there an autopsy?

Yes

## What test confirmed diagnosis?

(Signed)

S. B. MacReady

M. D.

, 19 (Address)

J. H. H.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Patterson, N.J. Jan 30 1922

## 20 UNDERTAKER

ADDRESS

John O'Mitchell Esq. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



THE JOHNS HOPKINS HOSPITAL

Feb 2, 1922

Mr. C. Hampden Jones  
Board of Health  
Baltimore Md.

My dear Mr. Jones,

In regard to Mr. Harvey  
Ferenbach who died Jan 29, 1922, I  
am sending the following note. An  
exploratory uretrotomy was done on  
Jan 25, 1922 for the relief of a  
ureteral calculus and hydronephrosis on  
the left side. No calculus was found  
but a ureteral stricture was found  
at the point where the left seminal  
vesicle which was markedly indurated  
and bound down with adhesions, touched  
it. Evidently the patient had a  
chronic vesiculitis which dated back to  
an attack of gonorrhea 20 years previous.  
Mr. Ferenbach was operated on

THE JOHNS HOPKINS HOSPITAL

again on Jan 28, 1922 because of  
symptoms of acute peritonitis.

I am enclosing the pathological  
report of Mr. Blech. In our history  
the death will go down as due to  
paralytic ileus secondary to the  
extravasation of urine, rather than  
due to acute peritonitis.

Hoping this is sufficient  
for your records, I am

Very respectfully yours.

P. B. Mac Crady

THE JOHNS HOPKINS UNIVERSITY  
DEPARTMENT OF PATHOLOGY  
8. W. COR. WOLFE AND MONUMENT STREETS  
BALTIMORE, MARYLAND

Samy Trenbach act 44

Autopsy 11. A.M., 30 January, 1922.

Provisional Anatomical Diagnosis.

Hydronephrosis. Hydrometer. Nephrolithiasis.

retical stone. Puncture wound of left meter.

retical stricture (left). Localized peritonitis +

extravasation into subperitoneal tissues in left

iliac fossa. Cystic (?) scars in liver. Pulmonary

edema.

Isaac Y. Och, M.D.



MARGIN RESERVED FOR BINDING  
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 60766 HEALTH DEPARTMENT—CITY OF BALTIMORE 60766

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1742 East North Ave  
CITY OF BALTIMORE No. 1742 E North Ave ST. 8 WARD

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia A. Craig

(a) RESIDENCE No. 1742 East North Ave ST. 8 WARD.  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James H. Craig

6 DATE OF BIRTH (month, day, and year) Jan 20 1847

7 AGE Years 74 Months 4 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer) off  
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md  
(State or country)

10 NAME OF FATHER Henry Cook

11 BIRTHPLACE OF FATHER (city or town) Maryland  
(State or country)

12 MAIDEN NAME OF MOTHER Julia A. Martin

13 BIRTHPLACE OF MOTHER (city or town) France  
(State or country)

14 Informant Mrs. H. Whiteley Saunders  
(Address) 1742 E. North Ave

15 JAN 8 0 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 24 1922, to Jan 28 1922, that I last saw her alive on Jan 28 1922, and that death occurred, on the date stated above, at 7.15 p. m.  
The CAUSE OF DEATH\* was as follows:  
Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY Influenza  
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted Home  
If not at place of death? Home  
Did an operation precede death? No Date of  
Was there an autopsy? No

What test confirmed diagnosis Trauma Chemical  
(Signed) C. C. Macdonald M. D.

(Address) 1540 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Woodlawn Cemetery Jan 31 1922

20 UNDERTAKER ADDRESS  
H. Allen Fuller 3517 Spring St



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

*Lijewski*  
HEALTH DEPARTMENT—CITY OF BALTIMORE  
D 60767  
CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *317 S Callington ave* ST.: *1* WARD)

REGISTERED NO. *101*  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Edmund Lijewski*

(a) RESIDENCE. No. *317 S Callington ave* ST.: *1* WARD.

(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 28 1919*

7 AGE Years *2* Months *6* Days *1* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country)

10 NAME OF FATHER *Frank Lijewski*

11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country)

12 MAIDEN NAME OF MOTHER *Josephine Odachowski*

13 BIRTHPLACE OF MOTHER (city or town) *Poland* (State or country)

14 Informant *Frank Lijewski* (Address) *317 S Callington ave*

15 *JAN 30 1922* ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 29 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Jan 28*, 1922, to *Jan 29*, 1922, that I last saw him alive on *Jan 29*, 1922, and that death occurred, on the date stated above, at *9:00 P. m.*

The CAUSE OF DEATH\* was as follows:

*Neuro. Pneumonia - Diph.*

(duration) yrs. mos. *2* ds.

CONTRIBUTORY (Secondary) *Cavitation*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ☒

Did an operation precede death? *no* Date of ☒

Was there an autopsy? *no*

What test confirmed diagnosis? *none*

(Signed) *Frank Lijewski*, M. D.

19 (Address) *125 S. 1st St.*

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Holy Rosary Jan 31 1922*

20 UNDERTAKER ADDRESS

*John Weber 1803 Bank St.*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-6-19—H. P. Co.—1090 Bks.

60768

HEALTH DEPARTMENT—CITY OF BALTIMORE

Shana Bernstein

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

17 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

17 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

JAN 3 0 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart Disease

(duration) 10 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

60769

## CERTIFICATE OF DEATH.

113

D 60769

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1831 Right St. ST. 24 WARD)

### 2-FULL NAME

(a) RESIDENCE NO. 1831 Right St.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos.

ds. How long in U. S., if of foreign birth?

WARD

(If non-resident give city nr town and State)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 19, 1921

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 2 7

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

10 NAME OF FATHER Walter Burger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Margaret McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mrs. Burger (Address) 1831 Right St.

15 JAN 30 1922 ROBERT R. KRAUTER, Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27, 1922

17 I HEREBY CERTIFY, that I attended deceased from Jan 25, 1922 to Jan 27, 1922, that I last saw him alive on Jan 27, 1922, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH\* was as follows:

Acute Gastro Enteritis

CONTRIBUTORY (Secondary) Phthisis (duration) yrs. mos. 3 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed the diagnosis? Clinical (Signed) R. H. Campbell M. D.

(Address) 1644 Hancock

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cathedral Cem. Jan 30, 1922

20 UNDERTAKER

Margaret G. Flynn 1422 Right St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 60770

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C.

D 60770

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE  
(State or country)

PARENTS

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER  
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

JAN 30 1922

ROBERT R. KRAUTER,  
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Contributory  
(SECONDARY)

(Signed)

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS



D 60771

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60771

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL, ST. 23 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Charles Stallman

## (a) RESIDENCE. NO.

1336 S. Charles

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Minnie

## 6 DATE OF BIRTH (month, day, and year)

5-21-1891

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

30

8

6

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Brickman

(b) General nature of industry, business, or establishment in which employed (or employer)

073

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

## 10 NAME OF FATHER

Peter Stallman

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Bertha Miller

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

## 14

Informant (Address)

JOHNS HOPKINS HOSPITAL

## 15

Filed

JAN 30 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

1-27

1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan 27, 1922 to 1-27, 1922

that I last saw him alive on 1-27, 1922

and that death occurred, on the date stated above, at 9:50 p.m.

The CAUSE OF DEATH\* was as follows:

aneurysm of aorta

(duration) yrs. 6 mos. ds.

## CONTRIBUTORY (Secondary)

Syphilitic aortitis

(duration) 2 yrs. 0 mos. ds.

## 18 Where was disease contracted if not at place of death?

1336 S. Charles St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? x-ray

(Signed)

E. Coulters Andrews, M. D.

19 (Address)

Johns Hopkins Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Baltimore Cem

Jan 31 1922

## 20 UNDERTAKER

E. Schuman Son

ADDRESS, 1334

Johns St

D 60772

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE (No. *713*)FULL NAME *Mary E Miller*(Residence in Baltimore: No. *713*)

REGISTERED No. C

ST. *76* WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. (S.))

St.; yrs., *2* mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married*  
(Write the word.)6-DATE OF BIRTH, *July 3*, 18*88*  
(Month) (Day) (Year)7-AGE, *63* yrs. mos. ds. If LESS than 1 day, .... hrs. or .... min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work *Housewife*  
(b) General nature of industry, business, or establishment in which employed (or employer) *800*9-BIRTHPLACE, (State or Country), *Baltimore Md*10-NAME OF FATHER, *unknown*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Joseph R. Weikel*(Address) *713 D St N*

15-

JAN 30 1922

ROBERT R. KRAUTER,

Filed

191

Burial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 27*, 19*22*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Apoplexy*  
(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(Signed) *Mary E Miller* M. D. *Jan 30 1922* (Address) *1800 N. Charles St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, *Carmel*DATE OF BURIAL, *1/28/22*20-UNDERTAKER *Lilly's*ADDRESS *403 S. Myrtle*

N.B.—Every item of information should be given in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is important. See instructions on back of certificate.



**UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No further history.*



D52077B

## HEALTH DEPARTMENT—CITY OF BALTIMORE 60774

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

JOHNS HOPKINS HOSPITAL

ST.:

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Thomas Hoaglin

## (a) RESIDENCE. NO.

Spencer, W.C.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

24

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5 If married, widowed, or divorced

HUSBAND of

WIFE of

Sallie (Wife)

## 6 DATE OF BIRTH (month, day, and year)

July 20, 1866

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

55

6

9

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

W.C.

## 10 NAME OF FATHER

Jackson Hoaglin

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

W.C.

## 12 MAIDEN NAME OF MOTHER

Mary Wilkinson

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

S.C.

## 14

Informant

(Address)

JOHNS HOPKINS HOSPITAL

## 15

Filed

19

JAN 30 1922

ROBERT R. KAUTER,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan 29 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan 5, 1922, to Jan 29, 1922

that I last saw him alive on Jan 29, 1922

and that death occurred, on the date stated above, at 2:25 A.M.

The CAUSE OF DEATH\* was as follows:

Carcinoma (Quamous Cell) of Left Upper Jaw

(duration) yrs. 3 mos. 10 ds.

## CONTRIBUTORY (Secondary)

Meningitis + Brain Abscess

(duration) yrs. 4 ds.

## 18 Where was disease contracted

If not at place of death?

unknown

Did an operation precede death?

yes

Date of Jan 12/1922

Was there an autopsy?

yes

What test confirmed diagnosis?

Smear Fluid + Mass. Comp. of Section

(Signed)

Joseph H. Gardner, M. D.

(Address)

Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Saulbury N.C.

Jan 30 1922

## 20 UNDERTAKER

## ADDRESS

Joseph Ahrens

221 2way

D 60775

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60775

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3930 E. Pratt ST., 76 WARD)

## 2. FULL NAME

(a) RESIDENCE NO. 3930 E. Pratt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

JAN 30 1922

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 9, 1922 to Jan. 25, 1922.

that I last saw him live on Jan. 28, 1922.

and that death occurred, on the date stated above, at 2:20 p. m.

The CAUSE OF DEATH\* was as follows:

Acute Venous thrombosis over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

1.29.1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*As far as physician  
could determine no  
other abnormal condition.*

D 60776

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60776

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

Monell Park

REGISTERED NO.

CITY OF BALTIMORE: (No. 1121 Eighth

ST. 75 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Frederick Chas. Haefner

(a) RESIDENCE. NO. 1121 Eighth

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs

mos.

ds.

How long in U. S., if of foreign birth? 30 yrs

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Martha Haefner

6 DATE OF BIRTH (month, day, and year)

Feb 10 1876

7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

45

11

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

Goucher College

(c) Name of employer

Goucher College

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

August Haefner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Katherine Jacobson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Martha Haefner 1121 Eighth St.

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 27 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 20, 1922, to Jan 27, 1922,

that I last saw him alive on Jan 27, 1922,

and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis and Aortic Stenosis About (duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. Stuken Brack M. D.

Address 1412 Light St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park

DATE OF BURIAL

Jan 31, 1922

20 UNDERTAKER

L. W. Dill

ADDRESS

3109 Fredk. Ave.

CAUSE OF DEATH in plain terms, see instructions on back of certificate. TION is very important.

N 3 01922



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60777

D 60777

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1045 Arguith

ST. 10 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Florence Adelia Creamer

(Residence in Baltimore: No. 1045 Arguith

St. 35 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE,

White

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.) Single

## 6-DATE OF BIRTH,

Jan 15, 1889  
(Month) (Day) (Year)

## 7-AGE,

52 yrs., 13 ds.

If LESS than 1 day,  
...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular  
kind of work.  
(b) General nature of industry, business, or establishment in which  
employed (or employer)

Housework

9-BIRTHPLACE.  
(State or Country),

Baltimore Md

10-NAME OF  
FATHER,

David Creamer

11-BIRTHPLACE  
OF FATHER  
(State or Country),

Baltimore Md

12-MAIDEN NAME  
OF MOTHER

Mary Love

13-BIRTHPLACE  
OF MOTHER  
(State or Country),

Baltimore Md

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr H. Creamer

(Address)

1045 Arguith St

## 15-

Filed Robert P. Harrison,  
Registrar.

AN 301922 Social Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan 28, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Dec 24, 1921 to Jan 28, 1922

that I saw her alive on Jan 24, 1922

and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

(Duration) 4 yrs., mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) 10 yrs., mos. ds.

(Signed)

M. D.  
Jan 28, 1922 (Address) 446 Arguith St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Greenmount Cemetery

## DATE OF BURIAL,

Jan 31, 1922

## 20-UNDERTAKER

Johannah Cando

## ADDRESS

446 Arguith St

D 60778 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60778

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Helen Strop* ST., *7th* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Baby Boy Stein*

## (a) RESIDENCE NO.

*2938 McElderry*

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*1/27/22*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or 2 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Helen Strop  
Baltimore Md*

10 NAME OF FATHER

*Conrad Stein*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Newfound land.*

12 MAIDEN NAME OF MOTHER

*Elga Carlson*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Man.*

14

Informant

*Conrad L. Stein*

(Address)

*2938 McElderry St.*

15

*Robert F. Harrison*

19

Registrar

*Special Permit Clerk*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*1/28/22* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

*1/28/22*, 19 *22*, to *1/28/22*, 19 *22*

that I last saw him live on

*1/28/22*, 19 *22*

and that death occurred, on the date stated above, at

*10:28 p.m.*

The CAUSE OF DEATH\* was as follows:

*"Asphyxia."*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

*no* Date of

Was there an autopsy?

*yes.*

What test confirmed diagnosis?

*Exam of lungs.*

(Signed)

*Julius Holofcner*, M.D.

, 19

(Address)

*2938 McElderry St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*St. Marys Hospital**1/30/22*

20 UNDERTAKER

ADDRESS

*William Coof**5626 North*

CAUSE OF DEATH IN PLAIN TERMS: See instructions on back of certificate.

AN 3 0 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

60779

## CERTIFICATE OF DEATH.

D 60779

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital

ST.:

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William D. Carr(a) RESIDENCE. No. 32 N. Milton Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown6 DATE OF BIRTH (month, day, and year) 1851

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

70----

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Anne Arundel Co.,

(State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14

Informant (Address)

Hospital Records, Municipal Hospital.

15

Filed

Robert P. Harrison,

Registrar

N 8 01922

Serial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30 19 22

17

I HEREBY CERTIFY, That I attended deceased from

January 21, 1922 to January 30, 1922.that I last saw him alive on January 29, 1922.and that death occurred, on the date stated above, at 3:45 A.M.

The CAUSE OF DEATH\* was as follows:

Parkinson's Disease, Arteriosclerosis, hypertension, Chronic nephritis(duration) 30 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cerebral hemorrhage(duration) yrs. mos. ds. 10

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

Clyde Monie

M. D.

1/30/22 Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cedar HillFeb 1st 19 22

20 UNDERTAKER

ADDRESS

Wm Cook502 E Pratt

D 60780 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60780

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2579 Guilford Ave. ST. 12 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME Mary W. Frank

(a) RESIDENCE. NO. 2579 Guilford Ave. ST. 12 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Lifetime

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham S. Frank

6 DATE OF BIRTH (month, day, and year) Jan 14-1857

7 AGE

Years 65

Months -

Days 15

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

10 NAME OF FATHER Abraham Whitfield

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Bertha Hauser

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14

Informant (Address) Bessie A. Frank 2579 Guilford Ave

15

Filed

Robert P. Harrison, Registrar

Special Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 20, 1921, to Jan 29, 1922.

that I last saw her alive on Jan 29, 1922.

and that death occurred, on the date stated above, at 2:00 P. M.

The CAUSE OF DEATH\* was as follows:

Cancer of uterus

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic Exam. tumor by Dr. Cullen

(Signed) Wm. T. Vratson, M. D.

Jan 30 1922 Address) 2128 St Paul St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship

DATE OF BURIAL 1/31/22

20 UNDERTAKER David Sondheim

ADDRESS 1180 Mt Royal Ave

AN 3 01922



D 60781

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60781

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

JOHNS HOPKINS HOSPITAL

ST.:

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Rick Maravia

## (a) RESIDENCE. NO.

Bendbush W. Va.

ST.:

WARD

Bendbush W. Va.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Anterior

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

4-1-1912

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

9

9

27

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

West Va.

## 10 NAME OF FATHER

Rick Maravia

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Poland

## 12 MAIDEN NAME OF MOTHER

Mary

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Poland

## 14

Informant (Address)

JOHNS HOPKINS HOSPITAL

301922

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

1-28 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

1-6, 1922, to 1-28, 1922,

that I last saw him alive on 1-28, 1922,

and that death occurred, on the date stated above, at 5:40 P. M.

The CAUSE OF DEATH\* was as follows:

Brain tumor

## CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Yes

Date of

Jan 22-1/1922

Was there an autopsy?

Yes

What test confirmed diagnosis?

(Signed)

Emile Holman, M. D.

, 19

(Address)

Cypress Hill 24 St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Bendbush W. Va.

Jan. 30 1922

## 20 UNDERTAKER

## ADDRESS

Miss G. Schaffer 1816 E. Myrtle St.

D 60782

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60782

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *412 N. Exeter* ST.: *5* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Rosa Pellegrino*(a) RESIDENCE. NO. *412 N. Exeter* ST.: WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *8* yrs. — mos. — ds. How long in U. S., if of foreign birth? *8* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Widowed*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Anthony Pellegrino*

## 6 DATE OF BIRTH (month, day, and year)

*1859*

## 7 AGE

*62*

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Retired*

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Italy*

## 10 NAME OF FATHER

*Andrea Pellegrino*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Italy*

## 12 MAIDEN NAME OF MOTHER

*Anna Anglin*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Italy*

## 14

Informant (Address)

*Catherine Berda 412 N. Exeter St*

## 15

Filed

*Robert P. Harrison,*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *1-28-1922*17 I HEREBY CERTIFY, that I attended deceased from *Jan. 23*, 19*22*, to *Jan. 28*, 19*22*, that I last saw him alive on *Jan. 28*, 19*22*, and that death occurred, on the date stated above, at *11:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*cardiac paralysis*

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *m* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Chs. Yerta*

M. D.

, 19 (Address)

*210 Pearl St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*St Vincent Cemetery**1/31/22*

## 20 UNDERTAKER

## ADDRESS

*George J. Ruth 1735 Harford Ave.*

8 01922

Burial Permit Clerk.

D 60783

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5107 York Rd ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannah E. Slocum

(Residence in Baltimore: No. 5107 York Rd

St.; 3 yrs., mos. da)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

Female

## 4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

## 6-DATE OF BIRTH,

April 16, 1859 (Month) (Day) (Year)

## 7-AGE,

63 yrs. 9 mos. 12 ds.

If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife 637

## 9-BIRTHPLACE, (State or Country),

Baltimore County, Md.

## 10-NAME OF FATHER,

Philipp Slocum

## 11-BIRTHPLACE OF FATHER (State or Country),

Baltimore Co., Md.

## 12-MAIDEN NAME OF MOTHER

Jemima Taylor

## 13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore Co., Md.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Albus Slocum

(Address) 5107 York Rd

## 15-

Robert P. Harrison,

Registrar.

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

January 28, 1922 (Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

January 27, 1922, to January 28, 1922, that I saw her alive on Jan 28, 1922,

and that death occurred, on the date stated above, at 2:45 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Granulomatous Nephritis  
Arteriosclerosis

(Duration) 3 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) 3 yrs. mos. ds.

(Signed) George D. Bishop M. D.

Jan 28, 1922 (Address) 501 Sheridan Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 3 yrs. mos. ds. In the State 63 yrs. 9 mos. 12 ds.

Where was disease contracted, if not at place of death? Same

Former or usual residence 1007 Baumgardner Ave.

## 19-PLACE OF BURIAL OR REMOVAL,

London Park

## 20-UNDERTAKER

Philip Herwig

## DATE OF BURIAL,

Jan 28, 1922

## ADDRESS

2016 Orleans

D 60784 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60784

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3442 Belair Ave WARD 27)

## 2-FULL NAME

William Althaus

## (a) RESIDENCE No.

3442 Belair Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

66 yrs. — mos. — ds.How long in U. S., if of foreign birth? 66 yrs. — mos. — ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower5a If married, widowed, or divorced HUSBAND of the late Mary Hamel Althaus (or) WIFE of6 DATE OF BIRTH (month, day, and year) Nov 29/557 AGE Years 66 Months 1 Days 28 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sign Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self9 BIRTHPLACE (city or town) (State or country) City10 NAME OF FATHER John Althaus11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany14 Informant Mary M. Harris (Address) Shell Road Belgrade

15 Robert P. Harrison, 19 Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 192217 I HEREBY CERTIFY, That I attended deceased from Jan 2 1922 to Jan 27 1922 that I last saw him alive on Jan 26 1922 and that death occurred, on the date stated above, at 8:50 A. m. The CAUSE OF DEATH\* was as follows:Myocardial Regeneration  
acute suppurative  
(duration) yrs. 2 mos. 00 ds.CONTRIBUTORY acute Edema lungs  
(Secondary) (duration) yrs. 1 mos. 00 ds.18 Where was disease contracted if not at place of death? unknownDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Findings(Signed) M. D.F, 19 4-27 (Address) 800 N. Patt St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Balto Cem. DATE OF BURIAL Jan 31 192220 UNDERTAKER Philip Hernig ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that laymen can understand. See instructions on back of certificate.

13 01922



**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**  
[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salcsman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Chronic Interstitial Nephritis*

D 60785

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60785

## CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 11 Geo. Hospital)

2-FULL NAME

(Residence in Baltimore: No. 1726 Bradford St.)

WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

Registrar.

Serial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the remnins described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) (Coroner)

1-34, 102 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms. See instructions on back of certificate.

301922

D 60786 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60786

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3006 E. Baltimore ST., 6 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. 3006 E. Baltimore ST., 6 WARD

(Usual place of abode) Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Schultz

6 DATE OF BIRTH (month, day, and year) February 25 - 1842

7 AGE Years 79 Months 11 Days 3 If LESS than 1 day, ... hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 28 1922

17 I HEREBY CERTIFY That I attended deceased from October 10, 1922, to January 28, 1922.

that I last saw him alive on January 27, 1922, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH\* was as follows:

Carcinoma Brain

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Allen E. Buchanan M. D.

128, 1922 (Address) 3139 E. Baltimore St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

BALTIMORE CEMETERY

20 UNDERTAKER

J. A. Moran

DATE OF BURIAL

1-31-1922

ADDRESS 3006

E. Baltimore St.

JAN 30 1922

Burial Permit Clerk.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60787

## CERTIFICATE OF DEATH.

D 60787

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

603 Richmond ST. WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Ellen Lindley

## (a) RESIDENCE NO.

603 Richmond ST.

## WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

62 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

W.

## 5 Single, Married, (Widowed, or Divorced (write the word)

Widowed

## 6a If married, widowed, or divorced HUSBAND of (or) WIFE of

(Anthony) Richard

## 6 DATE OF BIRTH (month, day, and year)

Sept. 1831

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Housewife

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Manchester Eng

## 10 NAME OF FATHER

Alfred Smyth

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

England

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

## 14

Informant (Address)

May Moran 603 Richmond St

## 15

Filed

Robert P. Harrison,

Registrar

N3 01922 Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan 28 1922

## 17

I HEREBY CERTIFY, That I attended, deceased from

Jan 19 1922, to Jan 28 1922,

that I last saw him alive on Jan 28 1922,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Apoplexy

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Myocarditis

(duration) 6 yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Clinical

(Signed) H. W. Wheaton M. D.

19 (Address) 4235 York Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Burial at Calverton

2-1-1922

## 20 UNDERTAKER

## ADDRESS

J. G. Moran

E. Baltch



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60788

D 60788

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 N. Streper ST., 6 WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. 1 mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Married

6a If married, ~~widowed~~ (or) WIFE of

Herman Latchkey

6 DATE OF BIRTH (month, day, and year)

Dec 12 - 1863

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

58

1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Herman Latchkey 22 N. Streper St.

15

Robert P. Harrison

Special Permit Clerk

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 27 1922

17 I HEREBY CERTIFY, that I attended deceased from Jan 24, 1922, to Jan 27, 1922,

that I last saw her alive on Jan 27, 1922,

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH\* was as follows:

acute - Nephritis

(duration) yrs. mos. ds. 4

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John B. O'Brien M. D.

Address: Summit Ave + Potomac

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Inf Carmel Cemetery

20 UNDERTAKER

J. G. Moran

DATE OF BURIAL

1-31-1922

ADDRESS 3000

E. Baetoff

3 01922

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assoc.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No other abnormal  
condition Cause  
unknown.*

D 60789

## HEALTH DEPARTMENT—CITY OF BALTIMORE

60789

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 Harvey St.)

## 2-FULL NAME

Mary Clara Shubridge

## (a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

F

## 4 COLOR OR RACE

W

## 5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14 Informant (Address)

## 15 Filed

Robert P. Harrison Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

1.29.22

17 I HEREBY CERTIFY, That I attended deceased from 1.29.22 to 1.29.22

that I last saw him alive on 1.29.22

and that death occurred, on the date stated above, at 10.20 a.m.

The CAUSE OF DEATH was as follows:

Premature Birth

## CONTRIBUTORY (Secondary)

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## 20 UNDERTAKER

## DATE OF BURIAL

## ADDRESS

AN 291922

Burial Permit Clerk.

D 60790

## HEALTH DEPARTMENT-CITY OF BALTIMORE

60790

## CERTIFICATE OF DEATH

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 1300 Edmondson Ave.)

FULL NAME

(Residence in Baltimore: No. 1300 Edmondson Ave.)

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (If write the word)

married

6-DATE OF BIRTH

Nov

(Month)

23

(Day)

(Year)

7-AGE

64

yrs.

2

mos.

4

ds.

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Paper Carrier

Amen

9-BIRTHPLACE (State or country)

West Virginia

10-NAME OF FATHER

Daniel Webster Snyder

11-BIRTHPLACE OF FATHER (State or country)

West Virginia

12-MAIDEN NAME OF MOTHER

Linda Constatle

13-BIRTHPLACE OF MOTHER (State or country)

West Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robert R. Snyder

(Address)

1300 Edmondson Ave.

15. JAN 31 1922

Filed

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Jan.

27

1922

17-I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on Jan. 27, 1922, and that death occurred, on the date stated above, at 6:45 p.m.

The CAUSE OF DEATH\* was as follows:

Cirrhosis of Liver

General Anasarca &amp; Edema of Lung

Coughing

Thomas J. Talbot, M.D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted? If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park

20-UNDERTAKER

John J. Field 1200 N. Lombard



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60791

## CERTIFICATE OF DEATH.

REGISTERED No. C

90 D 60791

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 Fairmount Ave.)

## 2-FULL NAME

(Residence in Baltimore: No. 1523 Fairmount Ave.)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 18 yrs., mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

F

4-COLOR OR RACE

Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

6-DATE OF BIRTH,

March 27, 1872

7-AGE,

49 yrs., 10 mos., 1 da.

If LESS than 1 day, .... hrs. or .... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).House work  
D.B.

9-BIRTHPLACE, (State or Country),

MD.

10-NAME OF FATHER,

Thomas Ringold

11-BIRTHPLACE OF FATHER (State or Country),

MD.

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER (State or Country),

MD.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Thomas Ringold

(Address),

1523 Fairmount Ave.

15-JAN 31 1922

ROBERT R. KRAUTER,

Bureau Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan. 28, 1922

17- I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1919 to Jan. 28, 1922, that I saw her alive on Jan. 27, 1922, and that death occurred, on the date stated above, at 7 P. m. The CAUSE OF DEATH\* was as follows:

Acute Dilatation of Heart

CONTRIBUTORY (Secondary)

(Duration) 2 yrs., 4 mos., 2 H. 40 min.

(Signed) J. M. Hays

1/29/19, 1919 (Address) 513 N. Calumet St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, In the State, yrs., mos., da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Auburn

DATE OF BURIAL,

Jan. 31, 1922

ADDRESS

184 Cr.

20-UNDERTAKER

Brown &amp; Muland

Schneider

D 60792

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 103 12 Leonard St.)

2-FULL NAME

Claude B Raffle

(Residence in Baltimore: No. 103 12 Leonard St.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Feb 24

1887

(Month)

(Day)

(Year)

7-AGE,

34

yrs. 10 mos. 20 da.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Auditor  
3000 Mills  
Baltimore

9-BIRTHPLACE,

(State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER,

Claude B Raffle

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Mary Becker

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

E. Raffle

(Address)

1038 Leonard St.

15-

JAN 31 1922

ROBERT R. KRAUTER,

Filed

191

Burial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan 27

1922

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed)

J. H. Gustley, M. D.

153

(Coroner)

1922

(Address) 153 Leonard St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

In the

of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Lorraine Cemetery

Feb 1st 1922

20-UNDERTAKER

ADDRESS

Lilly &amp; Sons

4038 York

D 60793

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

113

D 60793

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 W. Pratt ST. WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

John Matulievic

(a) RESIDENCE. No. 126 W. Pratt ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

male

## 4 COLOR OR RACE

white

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Nov. 6, 1921

## 7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

2

23

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

## 10 NAME OF FATHER

Antanas Matulievic

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Lithuania

## 12 MAIDEN NAME OF MOTHER

Tafels Dru sink

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Lithuania

## 14

Informant (Address)

Antanas Matulievic 126 W. Pratt St

## 15

JAN 31 1922

ROBERT R. KRAUTER, Registrar Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 6, 1921, to Jan. 29, 1922,

that I last saw him alive on Jan. 29, 1922,

and that death occurred, on the date stated above, at 12.25 P. m.

The CAUSE OF DEATH\* was as follows:

gastro-enteritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

malnutrition (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

no

Did an operation precede death? Date of

no

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) John A. Buchness, M. D.

19 Address 650 Columbia Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

St Stanislovas

Feb 1 1922

## 20 UNDERTAKER

## ADDRESS

John Grebliauskas

425 S. Bay St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60794

## CERTIFICATE OF DEATH.

90 D 60794

## PLACE OF DEATH

CITY OF BALTIMORE (No. *129 S. Bond*)ST. *3*

WARD)

REGISTERED No. C

2-FULL NAME *Louis Cohen*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *129 S. Bond*)St. *32* yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *1865*  
(Month) (Day) (Year)7-AGE, *57* yrs. mos. ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *Merchant*  
(b) General nature of industry, business, or establishment in which employed (or employer) *04*9-BIRTHPLACE, (State or Country), *Russia*10-NAME OF FATHER, *Aaron Cohen*11-BIRTHPLACE OF FATHER (State or Country), *Russia*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Yetta Cohen*(Address) *129 S. Bond St*15- *JAN 31 1922* ROBERT R. KRAUTER,Burial Permit *Blank*

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *Jan 29*, 19*22*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest*  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest*, and that said deceased came to *death*  
(Inquest, autopsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Chronic Valvular*  
*heart disease*  
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.  
(Signed) *Henry Sykes* M. D.  
(Coroner) *101* (Address) *101 S. Charles St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the  
of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, *Hebrew Burial* DATE OF BURIAL, *Jan 31, 1922*20-UNDERTAKER *M. Gerson* ADDRESS *1127 E**Baltimore*

CAUSE OF DEATH in plain terms, to the informant. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60795

## CERTIFICATE OF DEATH.

D 60795

1-PLACE OF DEATH US.V. HOSP. #56

CITY OF BALTIMORE: (No. FORT MCHENRY MD. ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milledge C. Raiford.

(a) RESIDENCE NO. US. V. Hosp. #56 Ft. Fort St. Md. WARD

(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored. 5 Single, Married, Widowed, or Divorced, (write the word) Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE 19 yrs. Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Fla. (State or country)

10 NAME OF FATHER unknown.

11 BIRTHPLACE OF FATHER (city or town) unknown. (State or country)

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) unknown. (State or country)

14 Informant E.T. Rosebrock Registrar. (Address) US V. Hosp. #56 Balto. Md.

15 JAN 31 1922 ROBERT R. KRAUTER, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1921, to Jan. 29, 1922.

that I last saw him live on Jan 29, 1922,

and that death occurred, on the date stated above, at 2:05 a.m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis pulmonary acute military.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinic report.

(Signed) J. S. L. Surgeon (R). M. D.

1/29, 1922 (Address) U.S. V. Hosp. #56 Balto. Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE  
CERTIFICATE OF DEATH.

D 60796

1-PLACE OF DEATH

CITY OF BALTIMORE: (Municipal Tuberculosis Hospital)

2-FULL NAME John Breckel

(a) RESIDENCE No. 11 N. Luzerne st.  
(Usual place of abode)  
Length of residence in city or town where death occurred Unknown mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed,  
or Divorced (write the word)  
Widowed5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)  
Years Months Days

7 AGE

47

1875

If LESS than  
1 day, hrs.  
or min.8 OCCUPATION OF DECEASED  
(a) Trade, profession or  
particular kind of work

Laborer

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Unknown

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town)  
(State or country)

Maryland

10 NAME OF FATHER George Breckel

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Germany

12 MAIDEN NAME OF MOTHER Carrie Brown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Germany

14 Informant  
(Address)

Hospital Records

15 Filed

JAN 31 1922

ROBERT R. KRAUTER  
Burial Permit Clerk.

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

D 60796

WARD

ST.

How long in U. S., if of foreign birth?  
ds. yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28, 1922

17 I HEREBY CERTIFY, That I attended deceased from  
Feb. 20, 1920, to Jan. 28, 1922.that I last saw him alive on Jan. 28, 1922,  
and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH\* was as follows:

pulmonary tuberculosis

CONTRIBUTORY  
(Secondary)

(duration) 4 yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Unknown

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Sputum X-ray  
(Signed) Francis L. Dada, M.D.

1-28-22 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mount Carmel Cemetery  
L. Sander Sons

ADDRESS

Feb 1 1922

D 60797

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60797

1-PLACE OF DEATH *Univ Hospital*  
CITY OF BALTIMORE (No. *15* ST. *15* WARD)  
2-FULL NAME *Israel Goldstein*  
(Residence in Baltimore: No. *2902 Springhill Ave.* St.; yrs., *35* mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male*  
4-COLOR OR RACE, *White*  
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *M*  
(Write the word.)  
6-DATE OF BIRTH *Unkn*, *1874*  
(Month) (Day) (Year)  
7-AGE, *48* yrs. — mos. — ds. If LESS than 1 day, ... hrs. or ... min.?  
8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *Tailor*  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.  
(State or Country), *Russia*

PARENTS.  
10-NAME OF FATHER, *Vinkov*  
11-BIRTHPLACE OF FATHER (State or Country), *Russia*  
12-MAIDEN NAME OF MOTHER, *Unkn*  
13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Hewie*  
(Address) *1411 E. Baltimore St.*

15- *JAN 31 1922* *ROBERT R. KRAUTER,*  
Filed *191* *Burial Permit Clerk*

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *Jan 28*, 19*22*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

hereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:  
*Spirit bar located*  
*Multiple Fractures*  
(Duration) yrs. — mos. — ds. *2*

CONTRIBUTORY (Secondary) *Stroke*  
(Signed) *C. N. Clark* M. D.  
(Coroner) *Jan 29*, 19*22* (Address) *1411 E. Baltimore St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).  
At place of death... yrs. — mos. — ds. In the State... yrs. — mos. — ds.  
Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Nehrem Herring* DATE OF BURIAL, *1/31*, 19*22*

20-UNDERTAKER *Jack Lewis* ADDRESS *1411 E. Baltimore St.*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

D 60798

Morton Flax  
HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

10 ✓ D 60798

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital*)

2-FULL NAME

(a) RESIDENCE. NO. *1419 E. Eager*

(Usual place of abode)

Length of residence in city or town where death occurred *Life* mos.

ST.

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*white*5 Single, Married, Widowed,  
or Divorced (write the word)*single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Sept 4-1920*

7 AGE

*1**4**26*If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Balto.*

10 NAME OF FATHER

*Robert Flax*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Balto*12 MAIDEN NAME OF MOTHER *Pauline Lieberman*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Russia*14 Informant  
(Address)*John E. Balto*

15 Filed

JAN 31 1922

ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)16 DATE OF DEATH (month, day, and year) *Jan 30 1922*17 I HEREBY CERTIFY, That I attended deceased from  
*Jan 29 1922 to Jan 30 1922*  
that I last saw him alive on *Jan 30 1922*  
and that death occurred, on the date stated above, at *8:00 a.m.*

The CAUSE OF DEATH\* was as follows:

*Diphtheria nasal &  
laryngeal*

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY  
(Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted  
if not at place of death? *at home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Bluffa J. J. J.* M. D.(Address) *Sydenham Hospital*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Hebrew Herring Run*

20 UNDERTAKER

*Jack Lewis*

DATE OF BURIAL

*1/30 1922*

ADDRESS

*1411 E. Balto*



D 60799

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 113 Harrison)

FULL NAME

(Residence in Baltimore: No. 113 Harrison)

ST. 4

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. (da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH.

Unknown, 1856  
(Month) (Day) (Year)

7-AGE.

76 yrs., mos. (da.)

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Retired

9-BIRTHPLACE, (State or Country).

Russia

10-NAME OF FATHER.

Unknown

11-BIRTHPLACE OF FATHER (State or Country).

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country).

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lewis, 1411 E. Baltimore St.

15-

Filed

191

Burial Permit Registrar.

JAN 31 1922

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Jan 28 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.)

And that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Carbon monoxide poisoning, accidental

(Stor.)

(Duration) yrs. mos. (da.)

CONTRIBUTORY (Secondary)

(Signed) M. D. (Coroner.)

(Address) 1632 E. Baltimore St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. (da.) State yrs. mos. (da.)

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Rehrein McDaniel

DATE OF BURIAL.

29 - 1922

ADDRESS

20-UNDERTAKER

Jack Lewis 1411 E. Baltimore St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

60800

1-PLACE OF DEATH

CITY OF BALTIMORE: (Not for use in case of death in hospital or institution)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)  
Length of residence in city or town where death occurred

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)14 Informant  
(Address)

15

JAN 13 1922

ROBERT N. KRAUTER  
Burial Permit Clerk

## CERTIFICATE OF DEATH

WARD

WARD

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth?

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signature)  
(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

CAUSE OF DEATH  
TION is very important.  
See instructions on back of certificate.

D 60801 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

Bay View Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 76 WARD)

2-FULL NAME

Mary Keller

(a) RESIDENCE. NO.

3808 Mrs Pleasant Ave

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Aurora

6 DATE OF BIRTH (month, day, and year)

1848

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

JAN 31 1922

Burial Permit Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan. 30, 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 10, 1922 to Jan. 30, 1922 that I last saw her alive on Jan. 29, 1922

and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH\* was as follows:

Pneumo-Pneumonia (terminal)

CONTRIBUTORY (Secondary)

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Address

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Sacred Heart

20 UNDERTAKER

Nedell Dwyer &amp; Son

Jan 31 1922

ADDRESS 378 N

Information should be carefully supplied in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60802

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 Woodlawn Ave. ST. 27

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 12.)

2-FULL NAME Marion Shaw

(Residence in Baltimore: No. 103 Woodlawn Road St.; 20 yrs., mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE

White

5-STATUS  
~~Single~~  
WIDOWED  
(Write the word.)

## 6-DATE OF BIRTH

August 11<sup>th</sup>, 1853  
(Month) (Day) (Year)

## 7-AGE

68 yrs., 5 mos., 19 ds.

If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,  
(State or Country),

Allegheny Co., Md.

## 10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

## 12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles W. Shaw

(Address) Bel Air, Md.

## 15-

JAN 31 1922

Filed

Registrar.

BUREAU OF PUBLIC HEALTH

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

January 30, 1912  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

191 to Jan 30 1912

that I saw her alive on Jan 28 1912,

and that death occurred, on the date stated above, at 7<sup>30</sup> A.M.

The CAUSE OF DEATH\* was as follows:

Pericarditis Aneurysm

(Duration) 6 wks.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) John J. King M. D.

Jan 30, 1912 (Address) 1425 E. Canton St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Cumberland Md

## DATE OF BURIAL,

Feb 1<sup>st</sup>, 1922

## 20-UNDERTAKER

Henry J. Jenkins &amp; Sons Co.

## ADDRESS

Bel Air, Md.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60803

D 60803

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *564 Dolphin* ST. *17* WARD)

REGISTERED NO. C

## 2-FULL NAME

(Residence in Baltimore: No. *564 Dolphin* St. *38* yrs. *—* mos. *—* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE

*colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

6-DATE OF BIRTH

*Sept. 23, 1966*  
(Month) (Day) (Year)

7-AGE

*56 yrs. 4 mos. 5 ds.*

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Porter 070 Colonial Trust Co.*

9-BIRTHPLACE, (State or Country),

*Virginia*

10-NAME OF FATHER,

*Joseph Myers*

11-BIRTHPLACE OF FATHER (State or Country),

*Virginia*

12-MAIDEN NAME OF MOTHER

*Mary J. Cook*

13-BIRTHPLACE OF MOTHER (State or Country),

*Virginia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Robert R. Krauter (Wife)*(Address) *564 Dolphin St.*

15-

JAN 31 1922

191

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Jan. 28, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Jan. 22, 1922, to Jan. 28, 1922,*that I saw him alive on *Jan. 22, 1922,*and that death occurred, on the date stated above, at *—* m.

The CAUSE OF DEATH\* was as follows:

*Interstitial nephritis*(Duration) *7* yrs. *7* mos. *—* ds.

CONTRIBUTORY (Secondary)

*Anemia*(Signed) *W. V. Davis, M. D.**Jan. 30, 1922* (Address) *515 N. E. St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs. *—* mos. *—* ds. In the State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *—*

19-PLACE OF BURIAL OR REMOVAL.

*St. Ambrose Cemetery*

DATE OF BURIAL.

*Jan. 31, 1922*

20-UNDERTAKER

*Mr. M. Johnson*ADDRESS *1207**Ceding St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60804

## CERTIFICATE OF DEATH.

REGISTERED No. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1620 E Chase ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1H.)

## 2-FULL NAME

(Residence in Baltimore: No. 1620 E Chase St St.; 3 yrs., 28 mo., 28 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single  
(Write the word)6-DATE OF BIRTH. October 3, 1921  
(Month) (Day) (Year)7-AGE, 3 yrs., 28 mo., 28 ds. If LESS than 1 day, ...hrs. or...min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. None  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), Baltimore10-NAME OF FATHER, Gardner Holden11-BIRTHPLACE OF FATHER (State or Country), Hochester Co Md12-MAIDEN NAME OF MOTHER Jennie Holthaus13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Gardner Holden(Address) 1620 E Chase St

15-

ROBERT R. KRAUTER,

Filed JAN 31 1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 30, 1922  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 30 19122 to Jan 30 19122 that I saw him live on Jan 30 19122 and that death occurred, on the date stated above, at 720 E.  
The CAUSE OF DEATH\* was as follows:  
Pneumonia(Duration) 3 yrs., 28 mo., 28 ds.CONTRIBUTORY (Secondary) Pneumonia  
(Duration) 3 yrs., 28 mo., 28 ds.(Signed) W. H. Jones M. D.  
30, 19122 (Address) 203 N. Main St. Balto

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 3 yrs., 28 mo., 28 ds. In the State 3 yrs., 28 mo., 28 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

Holy Redeemer Cemetery Feb 1, 192220-UNDERTAKER Henry Lutz ADDRESS 1203 W. Broadway

## D 60805 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 D 60805

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 792 W-Saratoga ST., 4 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME. *Bernard Banks*

(a) RESIDENCE NO.

(Usual place of abode)  
Length of residence in city or town where death occurred 18 yrs. 10 mos.ST. 792 W-Saratoga ST. WARD (If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male.*

4 COLOR OR RACE

*Colored*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Boot Black.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from  
Jan 24 - 1922 to Jan 30 - 1922.  
that I last saw him alive on Jan 29 - 1922.  
and that death occurred, on the date stated above, at 6.05 A. M.

The CAUSE OF DEATH\* was as follows:

*Tuberculosis of lung*(duration) *Indefinite* yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

*Dr. Gargill*, M. D.

1-30, 1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

2/1/22  
ADDRESS

20 UNDERTAKER

*Samuel T. Hensley*, 578 N. Biddle

Registrar

Burial Permit Clerk

CAUSE OF DEATH IN PARTS OF THIS FORM IS VERY IMPORTANT. See instructions on back of certificate.

D 60806

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 775 W. Mulberry ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Johnson(a) RESIDENCE. No. 775 W. Mulberry ST. 4 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Col. 5 Single, Married, Widowed, or Divorced (write the word) Mar5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Johnson6 DATE OF BIRTH (month, day, and year) Unknown7 AGE 50 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wagon Driver(b) General nature of industry, business, or establishment in which employed (or employer) 023(c) Name of employer T. B. C. and9 BIRTHPLACE (city or town) (State or country) T. B. C. and10 NAME OF FATHER Stephen Johnson11 BIRTHPLACE OF FATHER (city or town) (State or country) West Point Md12 MAIDEN NAME OF MOTHER Jane Brown13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Point Md

14

Informant (Address) Annie A. Brooks  
775 W. Mulberry St

15

Filed Jan 31 1922ROBERT H. KRAUTER,  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 192217 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1922, to Jan 27, 1922, that I last saw him alive on Jan 27, 1922, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 2  
Acute pneumonia  
(duration) yrs. mos. ds. Unknown

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 1/2

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Woodward, M. D.  
737 W. Fayette, 1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 INTERTAKER

ADDRESS

St. Ambrose Jan 31 1922  
Successor P. H. Woodward 578 W. Biddle



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60807

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1917 Arlington Ave. ST. 27 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 917 Arlington Ave. St. 64 yrs. mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

male

## 4-COLOR OR RACE.

colored

## 5-SINGLE,

MARRIED, Single  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

January 22, 1854  
(Month) (Day) (Year)

## 7-AGE,

65

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work... Contractor  
(b) General nature of industry, business, or establishment in which employed (or employer)...

## 9-BIRTHPLACE,

(State or Country)

Fayette Co Va

## 10-NAME OF FATHER,

Henry Gibson

## 11-BIRTHPLACE OF FATHER

(State or Country),

Virginia

## 12-MAIDEN NAME OF MOTHER

Grace Mason

## 13-BIRTHPLACE OF MOTHER

(State or Country),

Virginia

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Antonia Gibson

(Address)

917 Arlington Ave. Torrance

## 15-

Filed

JAN 31 1922

ROBERT R. KRAUTER,

Registrar.

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan. 28, 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 22, 1922, to Jan. 25, 1922, that I saw him alive on Jan. 27, 1922, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH\* was as follows:

Interstitial Nephritis

(Duration) yrs. 2 mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. 6 mos. ds.

(Signed) H. V. Carr, M. D.

Jan. 28, 1922 (Address) 515 Myrtle

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Mt. Auburn

## DATE OF BURIAL,

Jan. 31, 1922

## 20-UNDERTAKER

Sam'l. Wheeler

## ADDRESS

578 N. Bedale

60808

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mount Hope Retrials* ST. *28* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Harriet Crawford Munder*

## (a) RESIDENCE. NO.

*Mount Hope Retrials*ST. *28* WARD. *Resident*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *2* yrs. *6* mos. *0* ds. How long in U. S., if of foreign birth? *69* yrs. *4* mos. *26* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Single*6 DATE OF BIRTH (month, day, and year) *1852-Sept-4*7 AGE *69* Years *4* Months *26* Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *MD*10 NAME OF FATHER *Charles F. Munder*11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country) *MD*12 MAIDEN NAME OF MOTHER *P. Richards Price*13 BIRTHPLACE OF MOTHER (city or town) *Alexandria* (State or country) *Va*14 Informant *Records of Mount Hope Retrials* (Address) *Mount Hope Retrials*15 *JAN 31 1922*

ROBERT R. KRALIER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 30* 1922

17

I HEREBY CERTIFY, That I attended deceased from *Sept 18* 1919, to *Jan 30* 1922that I last saw her alive on *Jan 30* 1922and that death occurred, on the date stated above, at *8.50 P.* m.

The CAUSE OF DEATH\* was as follows:

*Chr. Bright Complicated by Endocarditis*(duration) *3* yrs. *0* mos. *0* ds.CONTRIBUTORY *Chr Dementia* (Secondary) *alt*(duration) *40* yrs. *0* mos. *0* ds.18 Where was disease contracted *Baltimore* if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Frank J. Flannery* M. D.*Jan 31* 1922 (Address) *Mount Hope Retrials*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Green Mount Cemetery**Feb-2-1922*20 UNDERTAKER *STEWART & MOWEN COMPANY* (WILLIAM F. WOODEN, Successor)

ADDRESS

*103 W. NORTH AVE.*

See instructions on back of card.

D 60809 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2839-N-Calvert-St.

ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ignacia Ramos Robbins

(a) RESIDENCE. No. 2839-N-Calvert-St. ST. 12 WARD. (Resident)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs ? mos. ? ds. How long in U. S., if of foreign birth? 15 yrs ? mos. ? ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white Spanish 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jonathan Magruder Robbins

6 DATE OF BIRTH (month, day, and year) July-31-1863

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

58 5 23

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) None 037

(c) Name of employer None

9 BIRTHPLACE (city or town) Buenos Ayres (State or country) Argentine, S.A.

10 NAME OF FATHER Rosendo Ramos

11 BIRTHPLACE OF FATHER (city or town) not known (State or country) Spain

12 MAIDEN NAME OF MOTHER Maria Melo

13 BIRTHPLACE OF MOTHER (city or town) Buenos Ayres (State or country) Argentine, S.A.

14 Informant Mr. Jonathan M. Robbins (husband) (Address) 2839-N-Calvert-St., City.

JAN 31 1922

ROBERT B. KRAVITZ Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28th 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1921, to Jan 28, 1922, that I last saw him alive on Jan 28, 1922, and that death occurred, on the date stated above, at 9.15 P. M.

The CAUSE OF DEATH\* was as follows:

Cancer of Rectum

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sep 12/21

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Geo H. Stoddard M. D.

, 19 (Address) 5835 York Road

\*State the Disease Causing Death or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Prospect Hill Cem. TOWSON, MD. Feb 1-1922

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS

103 W. NORTH AVE.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60810

## CERTIFICATE OF DEATH.

90D 60810

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2018-Maryland-Av.

ST.: 12 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jemima Reese Richstein

(a) RESIDENCE. No. 2018-Maryland-Av.

ST. 12 WARD.

(Resident)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 6 mos. 3 ds. How long in U. S., if of foreign birth? 81 yrs. 6 mos. 3 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed
5a If married, widowed, or divorced		
HUSBAND of		
(or) WIFE of William F. Richstein		
6 DATE OF BIRTH (month, day, and year) July-26-1840		
7 AGE	Years	Months
	81	6
		Days
		3
If LESS than 1 day, hrs. or min.		

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER James M. Lester

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Reese

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mrs. Jemima Gittinger (daughter)

(Address) 2018-Maryland-Av.

15 JAN 31 1922 ROBERT H. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 4 1917 to Jan 29 1922

that I last saw her alive on Jan 29 1922

and that death occurred, on the date stated above, at 11:15 P. M.

The CAUSE OF DEATH\* was as follows:

Myocarditis (chronic)

(duration) 5 yrs. mos. ds.

CONTRIBUTORY Cause Mitral

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Robert H. Krauter, M. D.

19 3019 (Address) 2111 W. Maryland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

GREENMOUNT CEMETERY

Feb-1-22, 19

20 UNDERTAKER

ADDRESS

STEWART &amp; MOWEN COMPANY

103 W. NORTH AVE

(WILLIAM F. WOODEN, Successor)



D 60811

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 D 60811

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3815-Lloyd-Ave.

ST.: 28 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

WILLIAM HENRY CULLIMORE

(a) RESIDENCE. No. 4904-Liberty Heights-AV ST., 28 WARD. (Resident)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 80 yrs. 8 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	WIDOWER

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Emily Elizabeth Cullimore

6 DATE OF BIRTH (month, day, and year) May-29-1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	8	0	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer) Stationery Business

(c) Name of employer (self)

9 BIRTHPLACE (city or town) Cleveland  
(State or country) Ohio

10 NAME OF FATHER William H. Cullimore

11 BIRTHPLACE OF FATHER (city or town) not known  
(State or country) not known

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) not known  
(State or country) not known14 Informant William H. Cullimore Jr. (son)  
(Address) #4904-Liberty Heights Av.

15 Filed JAN 31 1922 ROBERT R. MASTER, Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1922

17 I HEREBY CERTIFY, That I attended deceased from  
Nov. 1, 1921, to Jan 29, 1922,  
that I last saw him alive on Jan. 29, 1922,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)	(duration)	yrs.	mos.	ds.
	1			
	(duration)	yrs.	mos.	ds.
	3			

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinary  
(Signed) Herbert C. Blaher, M. D.

19 (Address) 1014 W to Joffe

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Loudon Park Cemetery

Feb-1-22 19

20 UNDERTAKER STEWART & MOWEN COMPANY  
(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60812

## CERTIFICATE OF DEATH.

44 D 60812

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2106-W-North-Av.

ST.: 15 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME GEORGE CLINTON ADAMS

(a) RESIDENCE. No. 2106-W-North-Av.

ST. 15 WARD. (Resident)

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. ? mos. ? ds. How long in U. S. if of foreign birth? 61 yrs. 2 mos. 9 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX MALE 4 COLOR OR RACE WHITE 5 Single, Married, Widowed, or Divorced (write the word) MARRIED

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Ella Elizabeth Adams

6 DATE OF BIRTH (month, day, and year) Nov-21-1860

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

61 2 9

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Builder at the

(b) General nature of industry, business, or establishment in which employed (or employer) Mt. Vernon Shops of

(c) Name of employer Pennsylvania R.R.Co.

9 BIRTHPLACE (city or town) Hartford, Conn.

10 NAME OF FATHER Geo. Crane Adams

11 BIRTHPLACE OF FATHER (city or town) Wethersville Conn.

12 MAIDEN NAME OF MOTHER Hannah Snow

13 BIRTHPLACE OF MOTHER (city or town) Wethersville Conn.

14 Informant Mrs. Ella E. Adams, (wife)  
(Address) 2106-West-North-Av. City.

15 JAN 31 1922 ROBERT A. KRAUTER Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1921, to Jan 30, 1922, that I last saw him alive on Jan 29, 1922, and that death occurred, on the date stated above, at 12.40 a.m. The CAUSE OF DEATH\* was as follows:

Carcinoma Gastrica  
(duration) yrs. 8 mos. 2 ds.

CONTRIBUTORY Pulmonary Oedema  
(Secondary) (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gastric Analysis.

(Signed) W. S. Skilling M. D.

1-30, 1922 (Address) 4107 Liberty Light Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

LOUDON PARK CEMETERY

Feb-2-22

20 UNDERTAKER

STEWART &amp; MOWEN COMPANY

ADDRESS

(WILLIAM F. WOODEN, Successor)

103 W. NORTH AVE.

D 60813 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 D 60813  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 456 Furrow

ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mary Clara Cox Clara Mary Cox

## (a) RESIDENCE. NO.

456 Furrow

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 10 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

female

## 4 COLOR OR RACE

white

## 5 Single, Married, Widowed, or Divorced (write the word)

widowed

## 5a If married, widowed, or divorced

~~HUSBAND~~  
(or) WIFE ofEdward  
Charles E. Cox

## 6 DATE OF BIRTH (month, day, and year)

March 21-1845

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

76

10

9

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

## 10 NAME OF FATHER

Samuel Reader

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

Md.

## 12 MAIDEN NAME OF MOTHER

Susan Milburn

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

Md.

## 14

Informant  
(Address)Grace S. Reader  
456 Furrow St.

## 15

Filed

JAN 31 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk,

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

January 30 1922

## 17

I HEREBY CERTIFY, That I attended deceased from August 10, 1921, to January 30, 1922, that I last saw her alive on January 30, 1922, and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH\* was as follows:

Organic heart disease

(duration) 8 yrs. mos. da.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

## 18 Where was disease contracted

If not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Autopsy

(Signed) Chester Ireland, M. D.

1-30, 1922 (Address) 2532 Edmondson Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Bressman &amp; Co. 2 1922

20 UNDERTAKER ADDRESS

William C. 5025 N. 1st St.

Perrine  
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60814

## CERTIFICATE OF DEATH.

113 D 60814

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 Ringgold ST., 21 WARD)

## 2-FULL NAME

Katherine Perrine

## (a) RESIDENCE NO.

311 Ringgold ST.,

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced, (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Nov. 24 1921

## 7 AGE

Years

Months

Days

LESS than  
1 day, hrs  
or min.

2

5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

None

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

## (c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Balto Md

## 10 NAME OF FATHER

Harry Perrine

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Balto Md

## 12 MAIDEN NAME OF MOTHER

Sallie Safranck

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Germany

## 14

Informant  
(Address)Harry Perrine  
311 Ringgold St

## 15

JAN 31 1922

ROBERT R. TRAUTER,  
Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan 27 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan 22, 1922, to Jan 27, 1922,

that I last saw her alive on

Jan 28, 1922

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH\* was as follows:

Meningitis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Harry Boyd, M. D.

37 1922

Address 602 Columbia Ave

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

Holy Cross Cemetery Jan 31, 1922

## 20 UNDERTAKER

## ADDRESS

William Cook 502 E. North Ave

CAUSE OF DEATH in plain terms, so far as possible, on back of certificate. See instructions on back of certificate.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Gastro Enteritis*

D 60815 HEALTH DEPARTMENT—CITY OF BALTIMORE 60815

CERTIFICATE OF DEATH.

Registered No. C.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4235 York Rd. 27 Ward)

2-FULL NAME

(Residence in Baltimore: No. 4235 York Rd. St.; yrs. Life mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male White

4-COLOR OR RACE

5-Single, Married, Widowed, or Divorced. (Write the word.)

Widowed

6-DATE OF BIRTH

Jan 12, 1850 (Month) (Day) (Year)

7-AGE

72 yrs. 0 mos. 17 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Commissioner  
Mar

9-BIRTHPLACE, (State or Country).

Md.

10-NAME OF FATHER

Unknown

11-BIRTHPLACE OF FATHER, (State or Country).

Scotland

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER, (State or Country).

Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

JAN 31 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Jan 29, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

Thereon and from the evidence obtained by said inquest, autopsy or inquiry, I find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Apoplexy.

CONTRIBUTORY (Secondary)

(Signed)

John J. Inley M. D.

192 (Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Loudon Park Jan 31, 1922

20-UNDERTAKER.

Wm Cook, 502 E. North ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60816

## CERTIFICATE OF DEATH.

D 60816

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

Eutaw St. Mt. Vernon

ST.

WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Fannie Ware

## (a) RESIDENCE. NO.

Eutaw St. Mt. Vernon

ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

Life

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

F

## 4 COLOR OR RACE

C

## 5 Single, Married, Widowed,

or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Albert Ware

## 6 DATE OF BIRTH (month, day, and year)

Feb. 11, 1899

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

22

11

16

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Housewife

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore  
Md

## 10 NAME OF FATHER

Weeley Burley

## 11 BIRTHPLACE OF FATHER (city or town)

Baltimore  
Md

## 12 MAIDEN NAME OF MOTHER

Hattie Hall

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Baltimore  
Md

## 14

Informant  
(Address)Hattie Hall  
Mt. Vernon, Md

## 15

Filed

19

JAN 31 1922

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

1/28/22

## 17

I HEREBY CERTIFY, That I attended deceased from

1/4/22, to 1/28/22

that I last saw him alive on 1/25/22

and that death occurred, on the date stated above, at 10:30 A. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary T. B.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

no

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed)

J. B. Harkness, M. D.

(Address) 1216 D. H. Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Mt. Vernon Cemetery Jan 31 1922

## 20 UNDERTAKER

## ADDRESS

J. B. Harkness 102 E. Mulberry St

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4308 Maine Ave., West Forest Park WARD)

## 2-FULL NAME

Sarah Lynch

## (a) RESIDENCE. NO.

4308 Maine Ave., West Forest Park WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. 2 mos. 25 ds. How long in U. S., if of foreign birth? (If nonresident give city or town and State) yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

William Lynch

6 DATE OF BIRTH (month, day, and year) Nov. 4, 1843

7 AGE

78

2

25

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

Maryland

10 NAME OF FATHER

Thomas Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER Jane Gamble

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

James E. Lynch

3602 Gwynn Oak Ave.,

Howard Park

15

Filed

JAN 31 1922

ROBERT H. KRAUTH

JAN 31 1922

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29, 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 15, 1921, to Jan 29, 1922, that I last saw her alive on Jan 29, 1922, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Breast

CONTRIBUTORY (Secondary) (duration) yrs. 6 mos. ds.

Information of age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of Oct 10, 1921

Was there an autopsy? no

What test confirmed diagnosis? Microscopical.

(Signed) A. C. Smith, M. D.

4509 Gileadey Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Loudon Park Cemetery

DATE OF BURIAL

1/31, 1922

20 UNDERTAKER

Henry W. Mears &amp; Son 805

ADDRESS

N. Calvert



D 60818

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 S - Bethel

ST. 3 WARD)

## 2-FULL NAME

Jarvis Moore

## (a) RESIDENCE NO.

211 S - Bethel

(Usual place of abode)

Length of residence in city or town where death occurred

unknown

ST. WARD

(If non-resident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male Colored Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Husband

6 DATE OF BIRTH (month, day, and year)

7 AGE 40 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labour 040

(b) General nature of industry, business, or establishment in which employed (or employer)

Labour

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Unknown

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Lattie Moore 211 S Bethel St

15

Filed

JAN 21 1922

J. E. Williams Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-28-1922

17 I HEREBY CERTIFY, That I attended deceased from 1-1-1922, to 1-28-1922.

that I last saw him alive on 1-28-1922.

and that death occurred, on the date stated above, at 6:30 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Valvulitis

CONTRIBUTORY (Secondary)

(duration) Indefinite mos. ds.

(duration) Indefinite mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. E. Williams, M. D.

1-20-1922 (Address) 611 N. Caroline

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Laural Cemetery

Jan 31 1922

20 UNDERTAKER

ADDRESS 1725

Mrs Robert A Elliott

Bethel St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60819

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 Jackson

## 2-FULL NAME

(a) RESIDENCE. NO. 1401 Jackson

(Usual place of abode)

Length of residence in city or town where death occurred

8 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed or divorced, name of (or) WIFE of James Gittings

6 DATE OF BIRTH (month, day, and year) Oct 21, 1848

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

73

3

7

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Jamesville

(State or country) Ohio

10 NAME OF FATHER David Birds

11 BIRTHPLACE OF FATHER (city or town) unknown

(State or country)

12 MAIDEN NAME OF MOTHER Ellen Smith

13 BIRTHPLACE OF MOTHER (city or town) unknown

(State or country)

14

Informant

(Address) 1510 Jackson St.

15

JAN 31 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1922, to Jan 28, 1922,

that I last saw her alive on Jan 28, 1922, at 8.50 P.M.

and that death occurred, on the date stated above, at The CAUSE OF DEATH\* was as follows:

Cerebral Haemorrhage

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) Sidney H. Stuart, M.D.

(Address) 408 N. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park

20 UNDERTAKER

J. J. Hakey Sons

ADDRESS

1311 Light St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

60820

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2430 E. Lafayette Ave. ST. 8 WARD)

## 2. FULL NAME

(a) RESIDENCE NO. 2430 E. Lafayette Ave. ST. 8 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14

Informant (Address)

15

File

JAN 31 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Jan 22, 1922, to Jan 30, 1922, that I last saw her alive on Jan 29, 1922, and that death occurred, on the date stated above, at 1:50 A. M.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. A. Schaefer, M. D.

, 19 (Address) 53 E. Fulton Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

STANDARD  
**CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name organ; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior*



HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60821

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (N

2-FULL NAME

(Residence in Baltimore: No.

ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE,

MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

ROBERT R. KRAUTER,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest, autopsy or inquiry,

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

(State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.)

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH to be plain and important. See instructions on back of certificate.

D 60822

(Birdie Butler)  
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60822

## CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 3)

2-FULL NAME

(Residence in Baltimore: No. 105 Broad Alley)

REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *degen* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, *1* (Month) (Day) (Year)

7-AGE, *42* If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer) *above*

9-BIRTHPLACE, (State or Country), *unknown*

10-NAME OF FATHER, *unknown*

11-BIRTHPLACE OF FATHER (State or Country), *unknown*

12-MAIDEN NAME OF MOTHER, *unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Charles Robert Baker*(Address) *T. Baker St.*

15- Robert P. Harrison,

Filed *1922* 191 Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 18*, 19*22* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*, and that said deceased came to *death* (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Chronic Valvular Heart Disease*  
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (Duration) ... yrs. ... mos. ... ds.

Signed *Wm. J. Harrison* M. D. (Coroner) *1808 4th St.* (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Mt Auburn Cem.* DATE OF BURIAL, *Jan 28 1922*

20-UNDERTAKER, *Daniel Easton* ADDRESS *916*

CAUSE OF DEATH in plain terms, so important. See instructions on back of certificate.

31 1922

Serial Permit No. 1201 Registrar.

D 60823

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60823

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal HospitalST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Bell(a) RESIDENCE. No. 719 Druid Hill AveST. 11 WARD.

(If nonresident give city or town and State)

(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of ----6 DATE OF BIRTH (month, day, and year) 19047 AGE Years Months Days If LESS than 1 day, hrs. or min.  
17 -- -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Bus Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.  
(State or country)10 NAME OF FATHER John Bell11 BIRTHPLACE OF FATHER (city or town) Balto.,  
(State or country) Maryland12 MAIDEN NAME OF MOTHER Mamie Matthews13 BIRTHPLACE OF MOTHER (city or town) Balto.,  
(State or country) Maryland14 Informant Hospital Records,  
(Address) Municipal Hospital15 Filed Robert F. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 28<sup>th</sup> 2217 I HEREBY CERTIFY, That I attended deceased from  
January 14, 1922, to January 28, 1922  
that I last saw him alive on January 28, 1922  
and that death occurred, on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH\* was as follows:

Tubercular peritonitis(duration) yrs. 3 mos. ds.CONTRIBUTORY —  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted At home ?  
If not at place of death?Did an operation precede death? no Date of —Was there an autopsy? yesWhat test confirmed diagnosis? clinical study(Signed) L. H. Brumback M. D.Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Ashbury Cem Feb 2 1922

20 UNDERTAKER

ADDRESS

Emil E. E. E. St. Louis

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates. This is very important.

131-1922 Serial Permit 01011

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60824

D 60824

## CERTIFICATE OF DEATH.

REGISTERED No. C.

PLACE OF DEATH

CITY OF BALTIMORE (No. 914 St. Barnabas St.)

2-FULL NAME

(Residence in Baltimore: No. 914 St. Barnabas Court

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., 4 mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

31 1922

Bureau Permit Clerk.

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

And that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

191 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60825

D 60825

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Carter's Sanatorium* ST. *15* WARD)

## 2. FULL NAME

(a) RESIDENCE NO. *3934 Norfolk Ave*

(Usual place of abode)

Length of residence in city or town where death occurred *3* yrs. *3* mos. *3* ds.

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Harry F. Kittredge*6 DATE OF BIRTH (month, day, and year) *Aug 12, 1845*7 AGE Years *76* Months *5* Days *17* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Maryland*10 NAME OF FATHER *Geo. R. Collier*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Id.*12 MAIDEN NAME OF MOTHER *Lara Jane Hooper*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Id.*14 Informant (Address) *Henry Dale Curpin 3934 Norfolk Ave*15 *Robert F. Harrison* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan. 27 1922*17 I HEREBY CERTIFY, That I attended deceased from *Sept. 1, 1921* to *Jan. 27, 1922*.that I last saw him alive on *Jan. 28, 1922*, and that death occurred, on the date stated above, at *6 P. m.*

The CAUSE OF DEATH was as follows:

*Chronic Interstitial Nephritis*CONTRIBUTORY (Secondary) *Coronary* (duration) *3* yrs. *3* mos. *3* ds.18 Where was disease contracted *3934 Norfolk Ave* if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *J. B. Bess*, M. D.1-29, 1922 (Address) *5600 York Rd*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Salisbury Md*

DATE OF BURIAL

*Feb 1, 1922*20 UNDERTAKER *Wm J. McKinnison*

ADDRESS

*North 42*

CAUSE OF DEATH in plain terms, so that it may be understood by the coroner. See instructions on back of certificate.

N3 1 1922

Burial Permit Work.

D 60826

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60826

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 518 n Eden ST 5 WARD)

REGISTERED NO. C

## 2-FULL NAME

Vernon Stevens

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 518 n Eden

St.: yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male	4-COLOR OR RACE Col.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Mar.
6-DATE OF BIRTH Dec 18, 1911 (Month) (Day) (Year)		
7-AGE 1 yr. 11 mos. 11 ds.		If LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Soley		

PARENTS.	9-BIRTHPLACE, (State or Country), Baltimore
	10-NAME OF FATHER, Geo Stevens
	11-BIRTHPLACE OF FATHER (State or Country), Baltimore
	12-MAIDEN NAME OF MOTHER, Hermine Markum
	13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Stevens  
(Address) 518 n Eden

## 15-

Robert P. Harrison,

Burial Permit Clerk. Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH  
Jan 29, 1922  
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(Duration) yrs. mos. ds.

(Signed) J. J. Miles M. D.

1-31, 1922 Address 144 St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the  
of death yrs. mos. ds. Since yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, HOPKINS HOSPITAL

DATE OF BURIAL JAN 31 1922

20-UNDERTAKER Health, Commissioned Health, ADDRESS

D 60827

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60827

1-PLACE OF DEATH

Bay View Hospital

CERTIFICATE OF DEATH.

REGISTERED NO.

CITY OF BALTIMORE NO.

ST. 38 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Martin H. Cupp.

(a) RESIDENCE. NO.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male Black

4 COLOR OR RACE

5 Single, Married, Widowed,

or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1872

7 AGE

50.

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

No

12 MAIDEN NAME OF MOTHER

No

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

No

14

Informant (Address)

Bay View Hospital

15

Filed

Robert F. Harrison,

19

Registrar

Partial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan. 26, 1922

17

I HEREBY CERTIFY, that I attended deceased from

Nov. 11, 1921, to Jan 26, 1922

that I last saw him alive on Jan 26, 1922

and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH\* was as follows:

General Paralysis (of the throat)

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

H. Goddard Smith

1/30/1922 Address)

Bay View Hospital

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

ADDRESS

2261 C NVT

D 60828

## HEALTH DEPARTMENT—CITY OF BALTIMORE, D 60828

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital

ST.

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Avery

(a) RESIDENCE. No. 706 S. Charles St

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1885

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

36

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## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Walter Retig

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Lizzie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14

Informant (Address)

Hospital Records,

Municipal Hospital,

Robert P. Harrison,

19

Registrar

15

Filing

1922

Special Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 19 22

17

I HEREBY CERTIFY, That I attended deceased from January 23, 19 22, to January 27, 19 22, that I last saw her alive on January 27, 19 22, and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH\* was as follows:

Removal from myomata uteri

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Clyde Monell

M. D.

1/28/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

John

11th,

1922

7761 C NY



# CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Not malignant*

D 60829

HEALTH DEPARTMENT—CITY OF BALTIMORE  
CERTIFICATE OF DEATH.

D 60829

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital

2-FULL NAME James A. Orram

(a) RESIDENCE. NO. 911 W. Baltimore St.  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced (write the word)

Widowed

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1868  
Years Months Days

7 AGE

53

8 OCCUPATION OF DECEASED  
(a) Trade, profession or  
particular kind of work

Shoe cutter

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

New Jersey

10 NAME OF FATHER

James A. Orram

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Scotland

12 MAIDEN NAME OF MOTHER

Mary Jane Brady

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Scotland

14

Informant  
(Address)Hospital Records,  
Municipal Hospital

Robert P. Harrison

Registrar

15

JAN 1 1922

JAN 1 1922

ST. 18 WARD

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26 1922  
17 I HEREBY CERTIFY, That I attended deceased from  
December 14, 1921, to January 26, 1922.  
that I last saw him alive on January 26, 1922,  
and that death occurred, on the date stated above, at 9:10 P.M.  
The CAUSE OF DEATH\* was as follows:

Syphilitic aortic insufficiency

CONTRIBUTORY  
(Secondary)

Myocardial infarction

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Chas. McNeill

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

JAN 1 1922

D 60830

HEALTH DEPARTMENT—CITY OF BALTIMORE D 60830

## CERTIFICATE OF DEATH.

REGISTERED NO. 38

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Zachary Zegley(a) RESIDENCE. NO. 820 Sharp St. ST. 22 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----6 DATE OF BIRTH (month, day, and year) 18857 AGE Years Months Days If LESS than 1 day, hrs. or min. 36 -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia10 NAME OF FATHER Salva Zegley11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia14 Informant Hospital Records, Municipal Hospital. (Address)Robert P. Harrison,

Registrar

Notial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25 192217 I HEREBY CERTIFY, That I attended deceased from December 10, 1921, to January 25, 1922. that I last saw him alive on January 25, 1922. and that death occurred, on the date stated above, at 4 P.M. The CAUSE OF DEATH\* was as follows:Syphilitic aortic insufficiencyCONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.1/26/22 Address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITALJAN 31 1922

20 UNDERTAKER

ADDRESS

TION is very important. See instructions on back of certificate.

N 3 1 1922

D 60831

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60831

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

University Hospital

CITY OF BALTIMORE: (No.

Lombard &amp; Jones ST.

WARD)

2-FULL NAME

Mrs. Sarah Reddig

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No.

107 W. 20<sup>th</sup>

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

1

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Negro

5 Single, Married, Widowed

Widowed

or Divorced

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1872

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

50.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Md.

10 NAME OF FATHER

George West

11 BIRTHPLACE OF FATHER (city or town)

Va.

(State or country)

12 MAIDEN NAME OF MOTHER

Mary Carr

13 BIRTHPLACE OF MOTHER (city or town)

Va.

(State or country)

14

Informant

(Address)

Bucky Simms

107 W. 20<sup>th</sup> St.

15

Name

Robert P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1/28 1922

17

I HEREBY CERTIFY, That I attended deceased from

1/27 1922, to 1/28 1922,

that I last saw him alive on 1/28 1922,

and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH\* was as follows:

Aortic Regurgitation

(duration) 1 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

Pulmonary Edema

(duration) 12 hrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

At home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

Phys. Exam

(Signed)

J. E. Jones

M. D.

(Address)

107 W. 20<sup>th</sup> St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

JAN 31 1922

Commissioner Health

Burial Permit 61634



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60832

## CERTIFICATE OF DEATH.

D 60832

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes Hospital* ST., *25* WARD)2-FULL NAME *David Edmonds*(a) RESIDENCE NO. *9 Pinehills Ave* ST., *Violetville* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*M.*

4 COLOR OR RACE

*R.*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *8 1910*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*11 yrs.*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*School*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Maryland*

10 NAME OF FATHER

*Do not know*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Do not know*

12 MAIDEN NAME OF MOTHER

*Do not know*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Do not know*

PARENTS

14

Informant

(Address)

*Mrs. Louise Edmonds*  
*9 Pinehills Ave.*

15

Filed

*Robert F. Harrison*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 31 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Jan. 30, 1922*, to *Jan. 31, 1922*.(that I last saw him alive on *Jan. 31, 1922*)and that death occurred, on the date stated above, at *6:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Perforated Appendix - General Peritonitis*

(duration)

yrs.

mos.

3 ds.

CONTRIBUTORY

(Secondary)

*Leucemia*

(duration)

yrs.

mos.

1 ds.

18 Where was disease contracted

if not at place of death?

*Home*

Did an operation precede death?

*yes*

Date of

*1-30-22*

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Operation*

(Signed)

*W. C. Caldwell*, M. D.

, 19

(Address)

*St. Agnes Hosp.*

\*State the Disease Causing Death, of in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Western J. Cook*  
*5026 North*

CAUSE OF DEATH is very important. See instructions on back of certificate.

N3 1-1922

D 60833 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60833

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2009 Sinclair Ave 8 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mary Anna Marie Maher

## (a) RESIDENCE NO.

2009 Sinclair Ave 8

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 10 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Henry G. Maher

6 DATE OF BIRTH (month, day, and year)

Oct 30 - 1851

7 AGE

70

Years

Months

Days

If LESS than 1 day, hrs or min.

2

29

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 001

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Henry Dietz

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary Waldschmidt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

14

Informant (Address)

Walter Maher 2009 Sinclair Ave 8

15

19

Robert F. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 29 1922

17

HEREBY CERTIFY, That I attended deceased from

Nov 3, 1920, to Jan 29, 1922.

that I last saw him alive on Jan 28, 1922.

and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH\* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Physical Examination

(Signed)

W. H. Harrison

M. D.

30, 1922 (Address) 1100 North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Not buried

Feb 6 1922

20 UNDERTAKER

ADDRESS

Wm. G. O'Rourke 5026 North Ave

D 60834 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 Grindon

ST. WARD)

## 2-FULL NAME

Amelia O. Wheeler

(a) RESIDENCE NO.

114 Grindon Ave., Lauraville

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life yrs. mos. ds.

How long in U. S., if of foreign birth? Life yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Thomas B. Wheeler

6 DATE OF BIRTH (month, day, and year)

12/30/1867

7 AGE

54

Years

Months

0

Days

29

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

Geo. D. Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Caroline Wheat

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant

(Address)

Louise Wheeler  
114 Grindon Ave.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan. 29, 1922

17 I HEREBY CERTIFY, that I attended deceased from

Dec. 28<sup>th</sup>, 1921, to Jan. 29, 1922.

that I last saw her alive on Jan. 28, 1922.

and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH\* was as follows:

Acute Nephritis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Valvular Insufficiency

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 7-0 Date of

Was there an autopsy? NO

What test confirmed diagnosis? Analysis of Urine Microscope

(Signed) Joseph J. Herring, M. D.

19 (Address) 1807 N. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Western Cem.

DATE OF BURIAL

2/1/1922

20 UNDERTAKER

Wm. Cook, 5026 North Ave.

15 Filed 1922

19

Registrar

CAUSE OF DEATH is very important. See instructions on back of certificate.

best apt.

DU 101 FORM 16 CLARK.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No other abnormal  
condition.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60835

D 60835

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *407 South Seventh* ST., *76* WARD)

## 2. FULL NAME

(a) RESIDENCE NO. *202 South Seventh* ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred *9* yrs. *0* mos. *0* ds.How long in U. S., if of foreign birth? *90* yrs. *0* mos. *0* ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 ☐ Single, Married, Widowed, Divorced, (write the word)5a ☐ Married, widowed, or divorced

HUSBAND or (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 30 1922*17 I HEREBY CERTIFY, that I attended deceased from *Jan 2nd 1922* to *Jan 30th 1922*, that I last saw him alive on *Jan 29th 1922* and that death occurred, on the date stated above, at *1450* m.

The CAUSE OF DEATH\* was as follows:

*Mitral regurgitation**about 2* yrs. *0* mos. *0* ds. (duration)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*William Cook**502 E North*

CAUSE OF DEATH IS VERY IMPORTANT. See instructions on back of certificate.

N3

1922

D 60836

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60836

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 N. Linwood Ave. ST. 11 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Ruth A. Baldwin

## (a) RESIDENCE, NO.

519 N. Linwood Ave.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs.  mos.  ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow5a If married, widowed, or divorced (or) WIFE of Frank Baldwin6 DATE OF BIRTH (month, day, and year) Dec. 13, 18587 AGE Years 63 Months 1 Days 16 If LESS than 1 day, hrs.  or min. 

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Maryland10 NAME OF FATHER James Spriggs

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland12 MAIDEN NAME OF MOTHER Ruth Kirby

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

## 14

Informant Mrs. Harry W. Glaser  
(Address) 519 N. Linwood Ave.

## 15

Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 192217 I HEREBY CERTIFY, that I attended deceased from Jan 23 1922, to Jan 24 1922that I last saw him alive on Jan 24 1922and that death occurred, on the date stated above, at 10 45 A. M.The CAUSE OF DEATH\* was as follows: Chronic Obstructive Pulmonary Disease  
Valvular Heart Disease

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? C. H. Meyer, M. D.(Signed) 1/30, 1922 Address 26 34 E. Brehm St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Western CemeteryFeb. 1 1922

20 UNDERTAKER

ADDRESS

Wm. C. Black 927 N. Broadway

See instructions on back of form.

N3 1 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60837

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

## 2-FULL NAME

## (a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Nov 14 1844

## 7 AGE

77

Years

Months

Days

2

14

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Locomotive Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired

(c) Name of employer

B &amp; O

## 9 BIRTHPLACE (city or town) (State or country)

Mt. Airy Md

## 10 NAME OF FATHER

Thomas Fleming

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Mt Airy Md

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14 Informant (Address)

R. W. Fleming  
1326 Light St.

## 15 Filed

Robert V. Harrison

Registrar

AN 31 1922

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1922

17 I HEREBY CERTIFY, That I attended deceased from

Jan 1, 1921, to Jan 28, 1922.

that I last saw him alive on Jan 28, 1922.

and that death occurred, on the date stated above, at 8:00 p.m.

The CAUSE OF DEATH\* was as follows:

Chronic interstitial nephritis

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. Unknown

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. M. Stifler

134 1924 Address 1319 Light St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Western Ave

## 20 UNDERTAKER

Margaret G. Flynn

## 21 DATE OF BURIAL

Feb. 1 - 1922

## ADDRESS

1422 Light St

D 60838

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: No.

ST.

WARD)

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

60 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M.* 4 COLOR OR RACE *W.* 5 Single, Married, Widowed, or Divorced. (write the word) *Widower*

5a If married, widowed, or divorced

HUSBAND of

WIFE of

*Theresa C. Himmel*

6 DATE OF BIRTH (month, day, and year)

*Oct. 21st 1842*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*79**3**8*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired dairyman*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Private.*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Germany*

10 NAME OF FATHER

*John Himmel*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*do not know.*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*

PARENTS

14 Informant

(Address)

*George J. Himmel**817 Curtis Ave. Curtis Bay*

15

*Robert F. Harrison,*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Jan. 29 1922*

17

I HEREBY CERTIFY,

that I attended deceased from

*Jan 26, 1922*, to*Jan 29, 1922*,

that I last saw him alive on

*Jan 28, 1922*,

and that death occurred, on the date stated above, at

*4 p. m.*

The CAUSE OF DEATH\* was as follows:

*Bronchopneumonia*

(duration)

yrs.

mos.

3 da.

CONTRIBUTORY (Secondary)

*Severe bronchitis*

(duration)

yrs.

mos.

da.

18 Where was disease contracted if not at place of death?

*X*

Did an operation precede death?

*no*

Date of

*X*

Was there an autopsy?

*no.*

What test confirmed diagnosis?

(Signed)

*Geo. B. Davis*

M. D.

(Address)

*211 Church St., Curtis Bay,*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

*Holy Cross Cem.**Jan 29, 1922*

UNDERTAKER

ADDRESS

*Margaret S. Flynn**1421 High St.*

CAUSE OF DEATH—See instructions on back of Certificate. TION is very important

N3

1 1922

Burial Permit Clerk.



D 60839

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60839

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE (No. 701 Whitelock

2-FULL NAME Charles Koehler

(Residence in Baltimore: No. 701 Whitelock

REGISTERED No. C

St. 17 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male  
4-COLOR OR RACE, White  
5-SINGLE, Married  
MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Feb., 28th., 1885  
(Month) (Day) (Year)

7-AGE, 36 yrs., 11 mos., - da.  
If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, Garage Owner  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto, Md.

10-NAME OF FATHER, Abraham Koehler

11-BIRTHPLACE OF FATHER (State or Country), Holland

12-MAIDEN NAME OF MOTHER, Wilhelmina Undermach

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mabel Koehler

(Address) 701 Whitelock St.

15-

Robert P. Harrison,

101

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan., 28th., 1942.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy, or inquiry, I find that said deceased came to death on the day stated above.

18-CAUSE OF DEATH, as follows:

Shot through head  
(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Signed) M. D.

(Address) 1132 Roland

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore Cemetery

2/1/42

20-UNDERTAKER

ADDRESS

Chas. F. Evans & Son- 118 W. Mt Royal Ave.

D 60840

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 S. Sharp ST. 22 WARD)

## 2-FULL NAME

Carrie Howard

(a) RESIDENCE. No. 711 S. Sharp ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female Colored Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

53

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md

10 NAME OF FATHER

John Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Louisa Lawrence

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Margie Thomas 711 S. Sharp St

15

FEB 1 - 1922

ROBERT H. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 15 1921, to Jan 28 1922,

that I last saw him live on Jan 28 1922,

and that death occurred, on the date stated above, at 7:40 P.M.

The CAUSE OF DEATH\* was as follows:

Gas Intoxication (Chronic) Superadded to from Pulmonary

(duration) yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. 13 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Obstruction to lymphatics

(Signed) C. H. Harris M. D.

19 (Address) 711 S. Sharp St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn

Feb 1 1922

20 UNDERTAKER

ADDRESS

John H. Trading

142

CAUSE OF DEATH in plain terms, so that it can be understood by the layman. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No other history*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60841

## CERTIFICATE OF DEATH.

31 ✓ D 60841

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 748 Ryan ST. 21 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 748 Ryan St.; yrs. mos. d.s.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE.

Caucas5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

## 6-DATE OF BIRTH,

1879  
(Month) (Day) (Year)

## 7-AGE,

42 yrs. mos. ds. If LESS than 1 day, ... hrs. or ... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

## 9-BIRTHPLACE,

(State or Country), Baltimore

## 10-NAME OF FATHER,

Unknown

## 11-BIRTHPLACE OF FATHER

(State or Country), Unknown

## 12-MAIDEN NAME OF MOTHER

Unknown

## 13-BIRTHPLACE OF MOTHER

(State or Country), Unknown

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daisy Crowder(Address) 748 Ryan St.

15-

FEB 1 - 1922

ROBERT R. KRAUTER,

Filed 191 Burial Permit Clark

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan 30, 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Nov 2 1921, to Jan 30 1922,that I saw him alive on Jan 30 1922,and that death occurred, on the date stated above, at 5:30 p.m.

## The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(Duration) ... yrs. ... mos. ... ds.

## CONTRIBUTORY (Secondary)

Haemorrhage

(Duration) ... yrs. ... mos. ... ds.

(Signed) William S. Burlew M. D.Jan 31, 1922 (Address) 762 Dolphin

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Met. Auburn

## DATE OF BURIAL,

Feb. 3, 1922

## 20-UNDERTAKER

John H. Toadman

## ADDRESS

142 West St.



## HEALTH DEPARTMENT-CITY OF BALTIMORE

D 60842

## CERTIFICATE OF DEATH

D 60842

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in  
a hospital or institution,  
give its NAME instead of  
street and number and  
fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <i>Single</i>
6 DATE OF BIRTH <i>Nov 19, 1921</i> (Month) (Day) (Year)		
7 AGE <i>2</i> yrs. <i>12</i> mos. <i>12</i> ds. or min.? If LESS than 1 day, hrs.		
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <i>None</i>		
9 BIRTHPLACE (State or country) <i>Maryland</i>		
PARENTS	10 NAME OF FATHER <i>Milton B. Woodward</i>	
	11 BIRTHPLACE OF FATHER (State or country) <i>M.C.</i>	
	12 MAIDEN NAME OF MOTHER <i>Willie May Ballard</i>	
	13 BIRTHPLACE OF MOTHER (State or country) <i>Va</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

FEB 1 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

*Jan 31, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Jan 27, 1922, to Jan 31, 1922,*that I saw her alive on *Jan 27, 1922,*and that death occurred, on the date stated above, at *5 a* m.

The CAUSE OF DEATH\* was as follows:

*Broncho pneumonia*

(Duration) yrs. mos. ds.

Contributory (SECONDARY) *Broncho pneumonia*

(Duration) yrs. mos. ds.

(Signed) *Walter S. Meltz* M. D.*Jan 31, 1922* (Address) *2220 Garrison*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Western Cemetery**Feb 6, 1922*

20-UNDER-TAKER

ADDRESS

*John J. Lyle 1600 W. North*

N. B.-Every item of information on this certificate is very important. See instructions on back of certificate.

D 60843

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1804 Greenmount av

2-FULL NAME Catherine Georgia

(Residence in Baltimore: No. 1804 Greenmount av

WARD 12

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 3 yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH,

(Month) (Day) (Year) 1

7-AGE,

about 30 yrs

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

Servant. (Home 670)

9-BIRTHPLACE. (State or Country),

Greece

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert R. Krauter

(Address) 17 S. Calhoun

15-

FEB 1 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year) Jan 23/ 1922

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Myocardial Infarction

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary)

Died suddenly

(Duration) yrs. mos. ds.

(Signed) M. D. Riley (Coroner.)

January 31, 1922 Address 1639 Rindley

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place 6 days In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Woodlawn Cem

DATE OF BURIAL,

2-1-1922

20-UNDERTAKER

Robert Brooks &amp; Son

ADDRESS

Calhoun

CAUSE OF DEATH in plain terms important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

60844

## CERTIFICATE OF DEATH.

60844

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 E 42nd

## 2-FULL NAME

(Residence in Baltimore: No. 500 E 42nd

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

female

## 4-COLOR OR RACE

white

6-STATUS  
(Write the word.)  
Married

## 6-DATE OF BIRTH

Jan 18, 1893

## 7-AGE

89 yrs. 13 ds.

If LESS than 1 day,  
...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular  
kind of work.  
(b) General nature of industry, busi-  
ness, or establishment in which  
employed (or employer).9-BIRTHPLACE,  
(State or Country).10-NAME OF  
FATHER.

Geo Graham

11-BIRTHPLACE  
OF FATHER  
(State or Country).

Baltimore

12-MAIDEN NAME  
OF MOTHER

Mary Harris

13-BIRTHPLACE  
OF MOTHER  
(State or Country).

Baltimore

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

FEB 1 - 1922

ROBERT R. KRAUTER,

Registrar.  
Burial Permit Clerk.

ST. 27

WARD

REGISTERED NO. C

(If death occurred in a  
hospital or institution,  
give its NAME instead  
of street and number and  
fill out No. 18.)

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan 31, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from  
Jan 24<sup>th</sup> 1922, to Jan 31 1922,  
that I saw her alive on Jan 31 1922,  
and that death occurred, on the date stated above, at 10<sup>15</sup> P. m.  
The CAUSE OF DEATH\* was as follows:  
Paralysis  
(Duration) ... yrs. ... mos. ... ds.  
CONTRIBUTORY  
(Secondary) ... (Duration) ... yrs. ... mos. ... ds.  
(Signed) E. H. Duncan M. D.  
Feb 1, 1922 (Address) 5106 York Road\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,  
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the ... yrs. ... mos. ... ds. State ...

Where was disease contracted,  
if not at place of death?Former or  
usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

Washington DC

## DATE OF BURIAL,

Feb 1, 1922

## 20-UNDERTAKER

Robert Brinkman

## ADDRESS

Catharine Hall

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60845

D 60845

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1903 M<sup>th</sup> Henry ST. 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. 1903 M<sup>th</sup> Henry ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23/1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant

(Address) 1903 M<sup>th</sup> Henry ST.

15

FEB 1 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 16, 1922, to Jan 31, 1922,

that I last saw him alive on Jan 30, 1922,

and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

(duration) yrs. mos. 15 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) James A. H. D.

2/1, 1922 Address 1729 1/2 Lombard St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Fondren Park

Feb 3 1922

20 UNDERTAKER

ADDRESS

John Fields 1211 N. Lombard

TION is very important. See instructions on back of card.



D 60846

## HEALTH DEPARTMENT—CITY OF BALTIMORE

60846

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 W. Fayette

ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

John Martin Kesmodel

## (a) RESIDENCE. NO.

1628 W. Fayette

ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 4 mos. 12 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 18, 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

4

12

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore  
Maryland

10 NAME OF FATHER Harvey L. Kesmodel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore  
Maryland

12 MAIDEN NAME OF MOTHER Lily M. McCoy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore  
Maryland14 Informant Harvey L. Kesmodel  
(Address) 1628 W. Fayette Street

15 FEB 1 - 1922

ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30, 1922

17 I HEREBY CERTIFY. That I attended deceased from Jan. 21, 1922, to Jan. 30, 1922, that I last saw him alive on Jan. 30, 1922, and that death occurred, on the date stated above, at 3:28 P. M.

The CAUSE OF DEATH\* was as follows:

Acute Myocarditis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 1  
Broncho-Pneumonia  
(duration) yrs. mos. ds. 9

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1/31, 1922 (Address)

M. A. O'Neill, M. D.  
108 N. Fulton Ave.  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

2/1, 1922

20 UNDERTAKER

ADDRESS

Henry W. Mears &amp; Son 805 N. Calvert

D 60847

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Municipal Hospital

ST.

WARD

2-FULL NAME William Gould

(a) RESIDENCE NO. Unknown

(Usual place of abode)  
Length of residence in city or town where death occurred

ys. mos.

ST. WARD.  
(If nonresident give city or town and State)  
How long in U. S. If of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)  
Widowed

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1856

7 AGE

65

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore,  
Maryland

10 NAME OF FATHER Edward Gould

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Balto.,  
Maryland

12 MAIDEN NAME OF MOTHER Mary Hayes

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Balto.,  
Maryland

14 Informant  
(Address)

Hospital Records,  
Municipal Hospital

15 Filed

FEB 1-1922

ROBERT R. KRAUTER,

Public Health Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28 1922

17 I HEREBY CERTIFY, That I attended deceased from January 13, 1922, to January 28, 1922, that I last saw him alive on January 28, 1922, and that death occurred, on the date stated above, at 3:50 P.M.  
The CAUSE OF DEATH\* was as follows:

Pernicious Anemia

CONTRIBUTORY  
(Secondary)

18 Where was disease contracted  
If not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1/30/22 address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Greenmount Cemetery

20 UNDERTAKER

A. E. Hughes

DATE OF BURIAL

Feb. 1 1922

ADDRESS

424 N. Broadway

## HEALTH DEPARTMENT - CITY OF BALTIMORE

D 60848

60848

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH 2048 E Federal St

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No 2048 East Federal ST.: 8 WARD)

2-FULL NAME Elizabeth Werner.

(a) RESIDENCE. NO. 1625 1/2 Washington ST., 8 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John Werner

6 DATE OF BIRTH (month, day, and year) Jan. 16 1838

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

84

13

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

John Schleich

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary Shumpf

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant

(Address)

Mrs. Schultz daughter 2048 E. Federal St.

15

Filed

FEB 1 - 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 20, 1922, to Jan. 29, 1922,

that I last saw her alive on Jan. 29, 1922,

and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH\* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY

(Secondary)

Peritonitis

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? Other home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual clinical

(Signed) C. W. Woodhouse, M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Cemetery Feb. 1st 1922

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 UNDERTAKER ADDRESS

E. J. Panning &amp; Son - 1438 E. Fayette

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60849

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 452 E. Fort Ave.

ST. 24 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME Margaret Schaener

(a) RESIDENCE NO. 452 E. Fort Ave

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds.

How long in U. S., if of foreign birth? 65 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Henry Schaener

6 DATE OF BIRTH (month, day, and year) Sep 27 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
84		4	3	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Germany

10 NAME OF FATHER

Unger

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant Mrs. Moon  
(Address) 452 E. Fort Ave.

15

FEB 4 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1922

17

HEREBY CERTIFY, That I attended deceased from Jan 20, 1922 to Jan 30, 1922 that I last saw her alive on Jan 30, 1922

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH\* was as follows:

Acute cardiac dilatation

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) 5 yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) Sidney A. Streets M. D.

1/31, 1922 Address 405 N. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Cedar Hill Cemetery

Feb. 2nd 1922

20 UNDERTAKER

ADDRESS

E. J. Panning &amp; Son - 1460 Battery Ave.



D 60850

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

 REGISTERED NO.  
 (If death occurred in  
 a hospital or institu-  
 tion, give its NAME  
 instead of street and  
 number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 Poplar Grove ST., 20 WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 501 Poplar Grove

 (Usual place of abode)  
 Length of residence in city or town where death occurred

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed,  
or Divorced, (write the word)

married

 5a If married, widowed, or divorced  
 HUSBAND of  
 (or) WIFE of

George W. Washburn

6 DATE OF BIRTH (month, day, and year)

7 AGE

40

5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

FEB 1 - 1922

ROBERT R. KRAUTER,  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1922

17 I HEREBY CERTIFY, That I attended deceased from  
March 1, 1921, to Jan 31, 1922.

that I last saw her alive on Jan 31, 1922, at 6:15 P.M.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH was as follows:  
uterine carcinomaCONTRIBUTORY  
(Secondary)

(duration)

2 yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Feb. 1922

 \*State the Disease Causing Death, or in deaths from Violent Causes,  
 state (1) Means and Nature of Injury, and (2) whether Accidental,  
 Suicidal, or Homicidal. (See reverse side for additional space.)
19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

20 UNDERTAKER

DATE OF BURIAL

2-3

1922

ADDRESS

502 E. North

D 60851 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60851

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

ST. 12 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said... (Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Duration)....yrs.....mos.....da.

(Signed).....M. D. (Coroner.)

Jan 31, 1912 (Address).....

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs.....mos.....da. In the State....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms to be written in plain language on back of certificate. See instructions on back of certificate.

D 60852

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No

ST.

WARD)

## 2-FULL NAME

(a) RESIDENCE. No

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

FEB 1 - 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 60853

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2006 Spruce ST., 2 WARD)

## 2. FULL NAME

(a) RESIDENCE NO. 2006 Spruce ST., 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Boock

6 DATE OF BIRTH (month, day, and year) 1922

7 AGE 76 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Fred Boock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dantbrun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14

Informant (Address) James Byers 2006 Spruce St.

15

FEB 1 - 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1922 to Jan 27, 1922

that I last saw him alive on Jan 28, 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Test

(Signed) Geo. Heelan, M. D.

1937 Spruce St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Trinity Cemetery

20 UNDERTAKER

John A. Moran 3000 E. Baltosa

DATE OF BURIAL

1/2 1922

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60854

## CERTIFICATE OF DEATH.

49 D 60854

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4372 Bayfield Ave ST. 9 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

## (a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

35 yrs.

mos.

ds.

## WARD.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced (write the word)

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Day

If LESS than

1 day, hrs.

or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant  
(Address)

## 15

FEB 1-1922

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

## 17

I HEREBY CERTIFY, That I attended deceased from

Nov. 7, 1921, to Jan. 30, 1922

that I last saw him alive on Jan 29th, 1922

and that death occurred, on the date stated above, at 3:52 a.m.

The CAUSE OF DEATH\* was as follows:

Cancer of Larynx  
and trachea

(duration) yrs. 5 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Biopsy

(Signed)

W. J. Watson

M. D.

Jan 31, 1922 Address) 2128 St Paul St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Gordon Park Cem.

Feb 2 1922

## 20 UNDERTAKER

ADDRESS 2916

Philip Herring

Oleum

CAUSE OF DEATH SECTION is very important. See instructions on back of certificate.

D 60855

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60855

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sybillicham Hospital* ST. *10* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Willie Morgan*(a) RESIDENCE. NO. *418 N. 8th*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *2* yrs. *5* mos. *15* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*white*

5 Single, Married, Widowed, or Divorced (write the word)

*single*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Aug 16 - 1909*

7 AGE

Years

Months

Days

If LESS than

1 day. hrs.

or min.

*2**5**15*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Balto.  
Md.*

10 NAME OF FATHER

*Raymond Morgan*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Chaptico  
Md.*

12 MAIDEN NAME OF MOTHER

*Margaret Whitfield*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Balto.  
Md.*

14

Informant  
(Address)*Raymond J. Morgan  
1416 S. 8th*

15

Filed

*FEB 1 - 1922*

ROBERT R. KRAUSE

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 31 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan. 26 1922 to Jan 31 1922*that I last saw him alive on *Jan 31 1922*and that death occurred, on the date stated above, at *10:55 a.m.*

The CAUSE OF DEATH\* was as follows:

*Scarlet fever*

(duration)

yrs.

mos. *13*

ds.

CONTRIBUTORY  
(Secondary)*Bronchopneumonia*

(duration)

yrs.

mos. *3*

ds.

18 Where was disease contracted  
if not at place of death?*at home*Did an operation precede death? *No* Date ofWas there an autopsy? *no*

What text confirmed diagnosis?

(Signed)

*Bill Gessner*

M. D.

*1/31/22*

(Address)

*Sybillicham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Trinity Cem.**Feb 1 1922*

20 UNDERTAKER

*Philip Herwig*

ADDRESS

*2000  
Oleaus*

D 6083 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60856

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH 118 N Clinton St  
CITY OF BALTIMORE: (No. 1300 ST.; WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry H. Hugel (Hugel)

(a) RESIDENCE. NO. 118 N Clinton ST., WARD. (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? 63 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 63 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED Laborer

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Co Oper Factory

(c) Name of employer Hare town Maryland

9 BIRTHPLACE (city or town) (State or country) Maryland

## PARENTS

10 NAME OF FATHER Henry Hugel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Anna E. Roth (Address) 118 N. Clinton

15 Filed 1922 ROBERT R. KRAUSE Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1923

17 I HEREBY CERTIFY, That I attended deceased from 18 months, 19 ago to 19 that I last saw him alive on Jan 25, 1922, and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH\* was as follows: Sudden  
absence of pulse  
and respiration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Not at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? E. W. Jannet M. D.

(Signed) 3802 Bank St

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Oak Lawn Feb 1 1923

20 UNDERTAKER ADDRESS 2016 Orleans

Philip Henry

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60857

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1426 N. Luzerne ST.: 8 WARD)

## 2-FULL NAME

(a) RESIDENCE. NO. 1426 N. Luzerne ST.,

(Usual place of abode)  
Length of residence in city or town where death occurred

WARD.

(If nonresident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

PARENTS

14 Informant

(Address)

15

FEB 1-1922

ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1922

17 I HEREBY CERTIFY, That I attended deceased from

Jan 17 1922, to Jan 29 1922,

that I last saw her alive on Jan 28 1922,

and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH\* was as follows:

Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed)

19

(Address)

3003 St. Paul St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREATION OR REMOVAL

20 UNDERTAKER

Roth &amp; Turner

ADDRESS

1426 N. Luzerne



# CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Terminal Cerebral  
Hemorrhage*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60858

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)  
Length of residence in city or town where death occurred

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Cal

5 Single, Married, Widowed,  
or Divorced, (write the word)

married

5a If married, widowed, or divorced

~~HUSBAND~~ of  
~~WIFE~~ of

Mrs. Martha Mearns

6 DATE OF BIRTH (month, day, and year)

Dec 1866

7 AGE

55

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

upholsterer

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Lancaster Co, Va.

10 NAME OF FATHER

John J. Mearns

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Lancaster Co Va.

12 MAIDEN NAME OF MOTHER

Martha Kelley

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Lancaster Co Va.

14 Informant  
(Address)Martha Mearns  
907 Park Ave.

15

FEB 1 - 1922

ROBERT B. KRAUTER

Registrar

Burial Permit Clerk

ST. 11 WARD

ST. WARD

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1922

17 I HEREBY CERTIFY, That I attended deceased from  
1-23-22, 19, to 1-30-22, 19.

that I last saw him alive on " 19

and that death occurred, on the date stated above, at 3.05 A.M.

The CAUSE OF DEATH was as follows:

Acute Nephritis

CONTRIBUTORY (duration) yrs. mos. ds.  
Gen'l Debility 7 ds.  
(Secondary) (duration) yrs. mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. U. Cardozo, M. D.

1-31-1922 (Address) 1524 Otis Hill Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Lancaster

Feb 3 1922

20 UNDERTAKER

Samuel T. Henry

ADDRESS

578 N. Biddle

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN,

*No other history*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60859

## CERTIFICATE OF DEATH.

90 D 60859

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1521 Druid Hill av. ST. 14 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Ann E. Shields

## (a) RESIDENCE NO.

1521 Druid Hill av. ST.

## WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Sheppard Shields

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

71

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Na

## 10 NAME OF FATHER

John Saunders

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Na

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Na

## 14

Informant

(Address)

1521 Druid Hill av.

## 15

Filed

FEB 1 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 28, 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 13, 1922, to Jan 28, 1922.

that I last saw her alive on Jan 28, 1922.

and that death occurred, on the date stated above, at 3-15 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular heart disease

(duration) 4 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Robert J. Green, M. D.

1-30, 1922 (Address)

12011 9th St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

Samuel H. Henry

378 W. Biddle St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60860  
1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Hospital ST. 10 WARD)2-FULL NAME Ella Henson.(a) RESIDENCE. No. 1200 St. James St. ST. 10 WARD. (If nonresident give city or town and State)  
(Usual place of abode) 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18587 AGE Years 63 Months -- Days -- If LESS than 1 day, hrs. -- or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Old Mexico10 NAME OF FATHER John Gordon11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Old Mexico14 Informant (Address) Hospital Records, Municipal Hospital.15 Filed FEB 1 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28 192217 I HEREBY CERTIFY, That I attended deceased from January 24 1922 to January 28 1922. that I last saw her alive on January 27 1922. and that death occurred, on the date stated above, at 2:45 A.M.

The CAUSE OF DEATH\* was as follows:

Chronic myocarditis

CONTRIBUTORY (Secondary)

Myocardial insufficiency

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Autopsy(Signed) Alfred M. Merrill M. D.1/28/1922 Address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

National Cemetery

DATE OF BURIAL

Feb 2 1922

20 UNDERTAKER

John W. HendersonADDRESS 1000Emmott

D 60861

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60861

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. *2420 N. Stachton* St. *15* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *2420 N. Stachton* St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Male*

## 4-COLOR OR RACE,

*colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

## 6-DATE OF BIRTH,

*May 14, 1861*  
(Month) (Day) (Year)

## 7-AGE,

*61* yrs. *8* mos. *15* ds.

If LESS than 1 day, ... hrs. or ... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Police*(b) General nature of industry, business, or establishment in which employed (or employer). *General*

## 9-BIRTHPLACE, (State or Country),

*Md.*

## PARENTS.

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER (State or Country),

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER (State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Elivous A. Cop*(Address) *Catonsville, Md.*

FEB 1 - 1922

led.

191.

ROBERT R. KRAUTER,

Burial Permit Clerk,

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan. 29, 1922*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, au-*opsy* and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Cardiac hemorrhage*

(Duration) ... yrs. ... mos. ... ds.

## CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *J. T. Hennessey* M. D. (Coroner.)*Feb 1, 1922* (Address) *2002 E. Madison Ave.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

## Former or usual residence .....

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*St. Mary's Cemetery**Feb. 1, 1922*

## 20-UNDERTAKER

ADDRESS *1303**John H. Jones**Greenwood*

See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

60862

## CERTIFICATE OF DEATH.

38 D 60862  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 E. Oliver ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Vernon E. Derr

## (a) RESIDENCE. NO.

1621 E. Oliver

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Rebecca R. Derr

6 DATE OF BIRTH (month, day, and year)

Jan. 10 - 1859

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

63

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Paper Hanger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Cecil Co Md

10 NAME OF FATHER

Isaac Derr

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pennsylvania

12 MAIDEN NAME OF MOTHER

Susan Burr

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pennsylvania

14

Informant (Address)

Mrs. Barbara A. Derr, 1621 E. Oliver

15

File

FEB 1 - 1922 ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29 1922

17

I HEREBY CERTIFY, That I attended deceased from

Dec. 15, 1921, to Jan 29, 1922.that I last saw him alive on Jan 29, 1922.and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical signs & symptoms

(Signed)

Samuel Miller

M. D.

, 19 (Address)

1506 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Parkwood CemeteryFeb. 2 1922

20 UNDERTAKER

ADDRESS

William E. Schaeffer1816 Monument

**CERTIFICATE OF DEATH.**  
[Approved by U. S. Census and American Public Health Asso.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Syphilis*



## D 60863 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH  
CITY OF BALTIMORE: (No. 129)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)  
Length of residence in city or town where death occurred

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed,  
or Divorced (write the word)

single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

File

Robert F. Harrison, Registrar

Burial Permit Clerk.

ST. WARD.

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth?

yrs

mos.

ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from

Mar 1921 to Jan 31 1922

that I last saw him alive on Jan 31 1922

and that death occurred, on the date stated above, at 3:13 p.m.

The CAUSE OF DEATH\* was as follows:

Sout

CONTRIBUTORY

(Secondary)

Chronic paronychia

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes, partial

What test confirmed diagnosis? usual renal tests

(Signed)

Edward Novak M. D.

19 (Address) 821 N. Pat. PK Av.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oak Lawn Cemetery

2/3 1922

20 UNDERTAKER

Chas. J. Wauert &amp; Son

11801 Royal Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60864

## CERTIFICATE OF DEATH.

REGISTERED NO. C

60864

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 Arlington Ave. ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 912 Arlington Ave. St.; 60 yrs., 1 mos., 1 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Male

## 4-COLOR OR RACE,

White

5-SINGLE  
MARRIED  
WIDOWED,  
OR DIVORCED,  
(Write the word.)  
Widowed

## 6-DATE OF BIRTH,

Mar 16, 1840  
(Month) (Day) (Year)

## 7-AGE,

81 yrs., 10 mos., 15 ds.

If LESS than 1 day,  
...hrs. or ...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...  
Butter dealer  
Tradesman9-BIRTHPLACE,  
(State or Country).

A.C. Maryland

## 10-NAME OF FATHER,

Therute H. Robinson

## 11-BIRTHPLACE OF FATHER

(State or Country).

Md—

## 12-MAIDEN NAME OF MOTHER

Not known

## 13-BIRTHPLACE OF MOTHER

(State or Country),

Not known

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Stewart Robinson

(Address)

1636 Cole St.

## 15-

Filed

Robert P. Harrison

Registrar.

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan 31, 1922  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1922, to Jan 31, 1922, that I saw him alive on Jan 30, 1922, and that death occurred, on the date stated above, at ...m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage  
(Duration) 6 yrs., 6 mos., 9 ds.CONTRIBUTORY  
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed)

R. R. Harrison M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

London North County

## DATE OF BURIAL,

Feb 3, 1922

## 20-UNDERTAKER

Geo. Lumbach &amp; Son

## ADDRESS

647 W. Pratt St.

D 60865

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60865

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hunt Hope Retreat* ST. *28* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. *111 Hope Retreat* ST. *28* WARD.(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred *Life* yrs. *0* mos. *25* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced  
HUSBAND of (or) WIFE of *Mr. Sandkuhler*6 DATE OF BIRTH (month, day, and year) *Jan 9-1865*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *57*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Wife of Brewer - none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country) *MD*10 NAME OF FATHER *Gerard Brocksmith*11 BIRTHPLACE OF FATHER (city or town) *Germany*  
(State or country)12 MAIDEN NAME OF MOTHER *A. Hilmer*13 BIRTHPLACE OF MOTHER (city or town) *Germany*  
(State or country)14 Informant *Records of Hunt Hope Retreat*  
(Address) *111 Hope Retreat Baltimore Md.*15 Filed *Robert P. Harrison,* Registrar

Serial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 29* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *Jan 4<sup>th</sup>* 19 *22*, to *Jan 29<sup>th</sup>* 19 *22*, that I last saw him alive on *Jan 28<sup>th</sup>* 19 *22*, and that death occurred, on the date stated above, at *7.35 P.* m.

The CAUSE OF DEATH\* was as follows:

*Hepatitis - with Cerebral Complications, Coma and Eclampsia.*(duration) *0* yrs. *3* mos. *0* ds.CONTRIBUTORY *Acute Mania*  
(Secondary) (duration) *0* yrs. *3* mos. *0* ds.18 Where was disease contracted *Baltimore Md*  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Frank J. Flannery* M. D.  
*Jan 30* 19 *22* (Address) *Hunt Hope Retreat*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Holy Redeemer Chm.*

DATE OF BURIAL

*Feb 2* 19 *22*

20 UNDERTAKER

*Lilly & Zeiler*

ADDRESS

*403 S. Wolfe*

1-1922

# UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Chronic nephritis.*  
*Mental condition, coma,*  
*& eclampsia due to chronic*  
*nephritis. No further*  
*history. Primary nephritis.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60866

## CERTIFICATE OF DEATH.

X 90 D 60866

## PLACE OF DEATH

CITY OF BALTIMORE (No. *John & M. Lafayette* 14

2-FULL NAME

*Susman Sherwin*

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *Northampton, Mass.*St.: yrs. mos. *7* da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *single*6-DATE OF BIRTH, *Jan. 24, 1922*  
(Month) (Day) (Year)7-AGE, *44 yrs. 8 mos. 7 da.* If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *mechanical Tailor*  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Massachusetts*10-NAME OF FATHER, *Abraham Sherwin*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Hannah Metzger*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) *William Sherwin*  
(Address) *32 Maple, Northampton, Mass.*15- *1922 Robert P. Harrison, Registrar.*

Burial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH, *Jan. 31, 1922*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
*Death, Dilatation of heart*  
(Duration) yrs. mos. da. *5 minutes*CONTRIBUTORY (Secondary) *Ac. Excess Exertion*  
(Signed) *J. T. Hervey* M. D.  
(Coroner.)  
*Feb. 1, 1922* (Address) *202 Edmund St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).  
At place of death *John & M. Lafayette* yrs. mos. da. State yrs. mos. da.Where was disease contracted, if not at place of death? *2248 Brookfield Ave.*Former or usual residence *Northampton, Mass.*19-PLACE OF BURIAL OR REMOVAL, *Mass. Northampton Mass.* DATE OF BURIAL, *Feb. 1, 1922*20-UNDERTAKER, *J. Ahrens & Co* ADDRESS, *1611 North Ave.*

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60867

## CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 524 N. Fremont Ave. ST. 18)

2-FULL NAME

Virginia R. M. Pherson

(Residence in Baltimore: No. 524 N. Fremont Ave.)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 16. yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 4-COLOR OR RACE, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Jan. 31, 1922 (Month) (Day) (Year)

7-AGE, 69 yrs. 8 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Virginia

10-NAME OF FATHER, James Marchant

11-BIRTHPLACE OF FATHER, Va.

12-MAIDEN NAME OF MOTHER, Davis/Kron

13-BIRTHPLACE OF MOTHER, Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A. K. Smith

(Address) 524 N. Fremont Ave.

15- Robert P. Harrison, Registrar.

16- Burial Permit Clerk.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 31, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Organic heart disease

(Duration) yrs. 6 mos. 8 ds.

CONTRIBUTORY (Secondary) no history

(Signed) J. T. Harrison, M. D. (Coroner)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, 1922

20-UNDERTAKER, Address

Every item of information should be given in plain terms, so that it may be properly understood. CAUSE OF DEATH is particularly important. See instructions on back of certificate.

EB1-1922

D 60868

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60868

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No.

Franklin Square Hospital

Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

George W. Paucoast

(Residence in Baltimore: No.

1427 W Fayette St

St.; yrs., 58, mos., ..ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male  
4-COLOR OR RACE, white  
5-Single, Married, Widowed, or Divorced, (Write the word.) Married6-DATE OF BIRTH, June 3, 1863  
(Month) (Day) (Year)7-AGE, 58 yrs., 6 mos., 27 ds.  
If LESS than 1 day, ...hrs. or ...min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, no agent  
(b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Balt. City

10-NAME OF FATHER, John Paucoast

11-BIRTHPLACE OF FATHER, (State or Country), Balt. City

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country), Balt. City

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Mrs Paucoast

(Address), 1427 W Fayette St

15-

Robert P. Harrison,

Filed

1922

Burial Permit Clerk.

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 30, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or Inquiry

thereon and from the evidence obtained by said Inquest, autopsy or Inquiry, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Fracture Great wing of Sphenoid Bone  
Auto accident

(Duration) ... yrs., ... mos., 7 ds.

CONTRIBUTORY (Secondary) Hemorrhage into Brain

(Signed) James M. Benton M. D.

(Coroner)

700 E Chase St

1922 (Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death, 7 yrs., 7 mos., 7 ds. State, ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Edmonson Ave 186 St

Former or usual residence, 1427 W Fayette St

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

London Park Cemetery Feb. 2nd, 1922

20-UNDERTAKER, ADDRESS

E J Manning &amp; Son - 1460 Battery Ave

D 60869

Spec. 6-9-19—H. P. Co.—100¢ Bks.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60869

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1411 Hanover ST. 23 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Betty J. Webster

## (a) RESIDENCE, NO.

1411 Hanover ST.

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

female

## 4 COLOR OR RACE

W

## 5 Single, Married, Widowed, or Divorced (write the word)

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5 - 1920

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1728

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto md  
(State or country)10 NAME OF FATHER John W. Webster

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Croftfield md

## 12 MAIDEN NAME OF MOTHER

Hayle Horner

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Bischoff md

## 14

Informant (Address)

John W. Webster  
1411 Hanover

## 15

Date

July 1 - 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 - 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

July 31 - 1922 to July 1 - 1922that I last saw him live on July 1 - 1922and that death occurred, on the date stated above, at 29 m.

The CAUSE OF DEATH\* was as follows:

Laryngeal Edema(duration) — yrs. — mos. 1 ds.

## CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted If not at place of death? the homeDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Autopsy(Signed) W. B. Cunningham M. D., 19 (Address) 1340 1/2 Chelton

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Landon Park

## DATE OF BURIAL

July 2 - 1922

## 20 UNDERTAKER

H. B. Cunningham

## ADDRESS

517 N. Schenck

CAUSE OF DEATH in plain terms, so that it can be read by anyone. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60870

## CERTIFICATE OF DEATH.

REGISTERED NO. C

D 60870

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Square Hospital* ST.; *18* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Kirk Flew*(Residence in Baltimore: No. *801 W. Lexington* St.; *8* yrs., *5* mos., *18* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Male*

## 4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *married*

## 6-DATE OF BIRTH

*Aug 13, 1968*  
(Month) (Day) (Year)

## 7-AGE

*53* yrs., *5* mos., *18* ds.

If LESS than 1 day, ... hrs. or ... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*Mechanic*

## 9-BIRTHPLACE, (State or Country).

*Middleburg Pa*

## 10-NAME OF FATHER

*Kirk Flew*

## 11-BIRTHPLACE OF FATHER (State or Country)

*Philadelphia Pa*

## 12-MAIDEN NAME OF MOTHER

*Mary McElrath*

## 13-BIRTHPLACE OF MOTHER (State or Country)

*Harrisburg Pa*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Hospital Record*(Address) *Franklin Square Hospital*

## 15-

FEB 2 - 1922

ROBERT R. KRAUTER,

Burial Permit Officer

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*Jan 31, 1922*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Jan 1, 1922, to Jan 31, 1922,*  
that I saw him alive on *Jan 31, 1922,*  
and that death occurred, on the date stated above, at *8:15 p.m.*

## The CAUSE OF DEATH\* was as follows:

*Septicemia*  
(Duration) *4* yrs., *5* mos., *18* ds.

## CONTRIBUTORY (Secondary)

*Septicemia*  
(Duration) *2* yrs., *5* mos., *18* ds.  
(Signed) *Arthur Daily* M. D.  
*Jan 31, 1922* (Address) *1611 Randolph St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *9* yrs., *5* mos., *18* ds. In the State *9* yrs., *5* mos., *18* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

*801 W. Lexington St.*

## 19-PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*St. Marys Hospital* *Feb 3, 1922*

## 20-UNDERTAKER

## ADDRESS

*Walter Davis* *3307 Pine St.*

D 60871

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH. X 51 ✓

D 60871

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 801 Hamilton Street, 11 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Bluma Jane Lison*(a) RESIDENCE No. 801 Hamilton Street, WARD *Washington D.C.*

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 1 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Samuel Lison*6 DATE OF BIRTH (month, day, and year) *Aug 7 1848*7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*73 5 W*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

*House*

(c) Name of employer

*House*9 BIRTHPLACE (city or town) *Newark*  
(State or country) *Ohio*10 NAME OF FATHER *Geo. Callahan*11 BIRTHPLACE OF FATHER (city or town) *Ohio*  
(State or country)12 MAIDEN NAME OF MOTHER *Elizabeth Groves*13 BIRTHPLACE OF MOTHER (city or town) *Ohio*  
(State or country)14 Informant *Martha Lison*  
(Address) *Medison St.*15 *FEB 2 - 1922* ROBERT R. KRAUTER, Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 1 1922*

17 I HEREBY CERTIFY, That I attended deceased from

*Jan. 27 1922 to Feb 1 1922*that I last saw her alive on *Feb 1 1922*and that death occurred, on the date stated above, at *12:45 P. M.*

The CAUSE OF DEATH\* was as follows:

*Myocardial Insufficiency*(duration) *About* yrs. 6 mos. ds.CONTRIBUTORY *Inflammatory Rheumatism*  
(Secondary)

(duration) yrs. 6 mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physical inspection*(Signed) *A. H. Stansbury*, M. D.2-2, 1922 (Address) *714 Park Ave, Baltimore*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Sullivan Ind* *Feb 3 1922*

UNDERTAKER

ADDRESS

*Monterey*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60872

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *231 E University Parkway*)

## 2-FULL NAME

*Christina Stumpf*(a) RESIDENCE NO. *231 University Parkway*

(Usual place of abode)

Length of residence in city or town where death occurred *50* yrs.

mos.

yrs.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*6 If married, widowed, or divorced HUSBAND of (or) WIFE of *Frederick Stumpf*6 DATE OF BIRTH (month, day, and year) *July 16 1836*7 AGE Years *85* Months *6* Days *11* If LESS than 1 day, ...hra. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *Geo. Stubermann*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Stubermann*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*14 Informant *Mrs. Henry Osterman* (Address) *231 E University Parkway*15 *FEB 2 - 1922* ROBERT R. KRAUTER, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan. 31 1922*17 HEREBY, CERTIFY, That I attended deceased from *Sept 10, 1921* to *Jan 31, 1922* that I last saw him live on *Jan 31, 1922* and that death occurred, on the date stated above, at *8 P. M.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Clarence S. Smith*, M. D.(Address) *4706 Harford Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

*R. Stemann**3417 York*

CAUSE OF DEATH SECTION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60873

## CERTIFICATE OF DEATH.

100-001 60873

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 S Bond St. 3 WARD)

## 2-FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)  
Length of residence in city or town where death occurred 18 yrs. mos. ds.How long in U. S., if of foreign birth? 35 yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Patrick Carrigan6 DATE OF BIRTH (month, day, and year) Dec 8 18797 AGE 41 Years 1 Months 23 Days  
If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Spain10 NAME OF FATHER Crapetz11 BIRTHPLACE OF FATHER (city or town) (State or country) Spain12 MAIDEN NAME OF MOTHER Carrigan13 BIRTHPLACE OF MOTHER (city or town) (State or country) Spain

PARENTS

14 Informant Patrick Carrigan  
(Address) 714 S Bond St.15 Filed FEB 2 - 1922 ROBERT R. KRAUTER,  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 192217 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1922, to Jan 30, 1922.that I last saw her alive on Jan 30, 1922.and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH\* was as follows:

Bronchial pneumoniaCONTRIBUTORY (Secondary) Exhaustion  
(duration) yrs. mos. ds. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physical signs(Signed) Patrick Carrigan, M. D.19 (Address) 18 S Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Mount CarmelDATE OF BURIAL Feb 2 192220 UNDERTAKER Louis HeermannADDRESS 92 S Broad

CAUSE OF DEATH is very important. See instructions on back of certificate.



D 60874

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60874

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital. Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....Edward G. Wilder.....

(Residence in Baltimore: No. 1356 Towson St. St.; yrs. 25 mos. 10 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, Married. (Write the word.)

6-DATE OF BIRTH, March 16th, 1896. (Month) (Day) (Year)

7-AGE, 25 yrs. 10 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Wharf builder. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, John Wilder.

11-BIRTHPLACE OF FATHER, (State or Country), Virginia.

12-MAIDEN NAME OF MOTHER, Emma Hayes.

13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Wilder. (wife)

(Address) 1356 Towson St.

15-

Filed

FEB 2 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 20th, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Fracture of the skull. Accidental fall through sky-light cleaning snow from roof.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signature) (Coroner)

3641 1st St. (Address) 1017 S. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Accident Red C Oil Co. Key Highway &amp;

Former or usual residence Lawrence St.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Cedar Hill Cn Feb 2, 1922

20-UNDERTAKER, ADDRESS

Mrs J. E. Lawrence 1428 S. Charles

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60875

## CERTIFICATE OF DEATH.

REGISTERED NO.

D 60875

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 N. First ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. 222 N. First St ST., 25 WARD  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Baby6a If married, widowed, or divorced HUSBAND of (or) WIFE of —6 DATE OF BIRTH (month, day, and year) May 19217 AGE Years 8 Months 20 Days — If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —(b) General nature of industry, business, or establishment in which employed (or employer) —(c) Name of employer —9 BIRTHPLACE (city or town) Balto  
(State or country)10 NAME OF FATHER Julius R. Furth11 BIRTHPLACE OF FATHER (city or town) Balto  
(State or country)12 MAIDEN NAME OF MOTHER Sadie Branyan13 BIRTHPLACE OF MOTHER (city or town) Md.  
(State or country)14 Informant Julius Furth  
(Address) 222 N. First St15 FEB 2 - 1922 ROBERT R. KRAUTER  
Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 31 192217 I HEREBY CERTIFY, That I attended deceased from Jun 23, 1922, to Jun 31, 1922.that I last saw him alive on Jun 31, 1922.and that death occurred, on the date stated above, at 10 0 m.

The CAUSE OF DEATH\* was as follows:

Pneumonia(duration) yrs. mos. ds. 8

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At homeDid an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? Pyralis  
(Signed) John B. Hall, M. D.19 (Address) 1203 Light St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cedar Hill

DATE OF BURIAL

Feb 1 1922

20 UNDERTAKER

F.A. Krause & Son

CAUSE OF DEATH IS VERY IMPORTANT. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60876

## CERTIFICATE OF DEATH.

D 60876

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 40 E. Fort Ave. ST. 23 WARD)

## 2-FULL NAME

E. August Witte.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

40 E. Fort Ave., 23 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? 63 yrs. --- mos. --- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Widower.

5a If ~~Married~~ widowed, or ~~Married~~

HUSBAND of

(or ~~WIFE~~ of)

Margaret Witte.

6 DATE OF BIRTH (month, day, and year) Dec 24th. 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	74	1	7	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist.

(b) General nature of industry, business, or establishment in which employed (or employer) retired

(c) Name of employer B. &amp; O. R. R. Co.

9 BIRTHPLACE (city or town) Germany.  
(State or country)

10 NAME OF FATHER Frederick C. Witte.

11 BIRTHPLACE OF FATHER (city or town) Germany.  
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Mitten

13 BIRTHPLACE OF MOTHER (city or town) Germany.  
(State or country)14 Informant Mary Kauderer. (niece)  
(Address) 40 E. Fort Ave.15 FEB 2-1922 ROBERT R. KRAUSE  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31 '22.

17 I HEREBY CERTIFY, That I attended deceased from October 21st 1921, to January 31st 1922, that I last saw him alive on January 21st. 1922, and that death occurred, on the date stated above, at 2.15 p. m. The CAUSE OF DEATH\* was as follows:

Chronic Bronchitis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY Oedema of the Lungs.  
(Secondary)

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed)

2/1/22. (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Balto Cemetery

DATE OF BURIAL

Feb 2 1922

20 UNDERTAKER

F. A. Krause &amp; Son 703 Hanover

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60877

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital

ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Smith(a) RESIDENCE. NO. 913 W. Franklin St

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871-? 7 AGE Years Months Days If LESS than 1 day, hrs. or min. 50-? -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland10 NAME OF FATHER Joseph Smith11 BIRTHPLACE OF FATHER (city or town) Baltimore, (State or country) Maryland12 MAIDEN NAME OF MOTHER Susam Semp13 BIRTHPLACE OF MOTHER (city or town) Balto., (State or country) Maryland14 Informant Hospital Records, (Address) Municipal Hospital.15 Filed 19 ROBERT R. KRASLER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30 192217 I HEREBY CERTIFY, That I attended deceased from January 25, 1922, to January 30, 1922, that I last saw her alive on January 30, 1922, and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH\* was as follows:

BronchopneumoniaCONTRIBUTORY (Secondary) (duration) yrs. mos. ds. 5

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? (Signed) Chas. H. Hill, M. D.1/31/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Graveyard (Cemetery)

DATE OF BURIAL

2/2/22

ADDRESS

108 W. NORTH AVE.20 STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60878

## CERTIFICATE OF DEATH.

REGISTERED NO. C

D 60878

## PLACE OF DEATH

CITY OF BALTIMORE (No.

1333 Carroll

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## FULL NAME

William J. Brown

St.; yrs., mos., ds.)

(Residence in Baltimore: No.

1333 Carroll

## PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. Male  
4-COLOR OR RACE. Colored  
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single (Write the word.)

6-DATE OF BIRTH. May 13, 1872  
(Month) (Day) (Year)

7-AGE. 49 yrs. 8 mos. 16 ds.  
If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. Robber  
(b) General nature of industry, business, or establishment in which employed (or employer). First Ford

9-BIRTHPLACE, (State or Country). Balt. City.

PARENTS.  
10-NAME OF FATHER. James R. Brown  
11-BIRTHPLACE OF FATHER (State or Country). Maryland  
12-MAIDEN NAME OF MOTHER. Mary J. Smith  
13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Ballard

(Address) 1333 Carroll St

15-

Filed. FEB 2-1922 191. Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 25, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:  
Lobar Pneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Signed) James M. Denton M. D.  
(Coroner.)

June 30, 1922 (Address) 200 E. Chan St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. ... yrs. ... mos. ... ds. In the ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence. ...

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, ...

20-UNDERTAKER ADDRESS ...

A. Jones 207 S. Stricker St

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60879

D 60879

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *14* WARD)

### 2-FULL NAME *James Warfield*

(a) RESIDENCE. NO. *1345 W. North Ave.* ST. *14* WARD. (If nonresident give city or town and State)

Length of residence in city or town where death occurred *life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widower*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Elizabeth Warfield*

6 DATE OF BIRTH (month, day, and year) *Aug 12 1859*

7 AGE Years *66 yrs.* Months Days If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Sheet metal worker*

(b) General nature of industry, business, or establishment in which employed (or employer) *084*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Md.*

10 NAME OF FATHER *Benj. Warfield*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md.*

12 MAIDEN NAME OF MOTHER *Letta Shipley*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*

14 Informant *James Warfield* (Address) *2420 Francis St.*

15 *FEB 2 - 1922* REGISTRAR *ROBERT R. KANTER* Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan. 31, 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Jan. 27, 1922*, to *Jan. 31, 1922*, that I last saw him alive on *Jan. 31, 1922*, and that death occurred, on the date stated above, at *10:05 P.m.*

The CAUSE OF DEATH\* was as follows:  
*Chronic diffuse nephritis*  
*Myocarditis*  
*Cardiac dilatation*  
*unknown* (duration) yrs. mos. ds.

CONTRIBUTORY *Broncho-pneumonia* (Secondary) (duration) yrs. mos. *4* ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Physical diagnosis*

(Signed) *J. Willis Grayton*, M. D.

, 19 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Linden Park* DATE OF BURIAL *FEB 2 1922*

20 UNDERTAKER *Chenoweth & Son Chestnut Ave*

CAUSE OF DEATH in parentheses. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60880

D 60880

## CERTIFICATE OF DEATH.

31

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 Myrtle St. 17 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Name Reid

## (a) RESIDENCE. NO. 1207 Myrtle St.

(Usual place of abode)

## WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

LIFE

mos.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

col

## 5 Single, Married, Widowed, or Divorced (write the word)

married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Nov. 25/92

## 7 AGE

29

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

## 10 NAME OF FATHER

Charles White

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore Md.

## 12 MAIDEN NAME OF MOTHER

Fannie Barmes

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md.

## 14

Informant (Address)

Henry Reid 1207 Myrtle St.

FEB 2 - 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Jan 29 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Dec 4, 1922, to Jan 29, 1922,

that I last saw her alive on Jan 29, 1922,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary  
Scurvy  
Scurvy

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. 4 ds.

## 18 Where was disease contracted

If not at place of death?

unknown

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Phys. Exam.

(Signed) Fannie Wagner, M. D.

(Address) 1006 Edmondson

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Mt. Auburn Cem.

Feb 2 1922

## 20 UNDERTAKER

Samuel Henry

## ADDRESS

578 W. Biddle

D 60881

HEALTH DEPARTMENT—CITY OF BALTIMORE

60881

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal HospitalST. 11

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Poulston(a) RESIDENCE. No. 722 Linden Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

38

--

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## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Washington Tanner

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Mary E. King

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia

14

Informant (Address)

Hospital Records

Municipal Hospital.

15

File FEB 2-1922

J E Wehr Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31 19 22

17

I HEREBY CERTIFY, That I attended deceased from

September 23, 20, to January 31, 1922.that I last saw her alive on January 31, 1922.and that death occurred, on the date stated above, at 10:15 A.M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of uterusUnknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cochemia - anemia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? yes

What test confirmed diagnosis?

(Signed) L. H. Brubaker M. D.1/31/1922 Address Municipal Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

2nd Auburn Mt. Feb 3 1922

20 UNDERTAKER

ADDRESS

George H. Holland 1631 Annie Hillman

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.



D 60882 HEALTH DEPARTMENT—CITY OF BALTIMORE D-60882

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2214 M<sup>c</sup>. Cullough St. 14

2-FULL NAME Agnes Neale

(Residence in Baltimore: No. 2214 M<sup>c</sup>. Cullough

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, March, 1855

(Month) (Day) (Year)

7-AGE 67

yr. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Laundry  
(b) General nature of industry, business, or establishment in which employed (or employer). 041

9-BIRTHPLACE, (State or Country), Md.

10-NAME OF FATHER, Mchman

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Muma

(Address) 2214 M<sup>c</sup>. Cullough St.

15-

FILED

FEB 27 1922

John A. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 31, 1922

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessey M. D.

(Coroner.) Feb. 1, 1922 (Address) 2802 Edgewood Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Md Auburn City

DATE OF BURIAL, Feb 5 1922

20-UNDERTAKER

ADDRESS

George H. Holland 1631 Kenning Hill Ave

D 60883 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 D 60883

## 1. PLACE OF DEATH

CITY OF BALTIMORE

WARD

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, ... hrs or ... min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 21, 1922, to Jan 31, 1922.

That I last saw him alive on Jan 31, 1922

and that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60884

D 60884

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of

(or WIFE of)

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

FEB 2 - 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 31 19 22

17 I HEREBY CERTIFY, That I attended deceased from that I last saw him alive on July 31, 19 22 and that death occurred, on the date stated above, at 1 20 A. m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What (or) confirmed diagnosis?

(Signed) Theo. Kaeberlein M. D.

Address 222. 3450 Fulton

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

D 60885

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Municipal Hospital*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. *19* ST. *19* WARD)2-FULL NAME *Rebecca Phillips*(a) RESIDENCE. NO. *3215 Colhoun* ST. *19* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced (write the word) *Wid*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Unknown*6 DATE OF BIRTH (month, day, and year) *1876*7 *83* Years *9* Months *8* Days *45* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*(b) General nature of industry, business, or establishment in which employed (or employer) *870*

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *MD*10 NAME OF FATHER *Thomas Martin*11 BIRTHPLACE OF FATHER (city or town) *Balto* (State or country) *MD*12 MAIDEN NAME OF MOTHER *Mary P. King*13 BIRTHPLACE OF MOTHER (city or town) *Balto* (State or country) *MD*14 Informant *Hosp. Records* (Address) *Municipal Hosp.*15 *Filed* *FEB 2 - 1922* *ROBERT R. KRAUTER* Registrar *Burial Permit Clerk*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan 30 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan 21 1922* to *Jan 30 1922* that I last saw him alive on *Jan 29 1922* and that death occurred, on the date stated above, at *8:45 m.*

The CAUSE OF DEATH\* was as follows:

*Chronic myocarditis, Chronic nephritis*(duration) *15* yrs. mos. ds.CONTRIBUTORY (Secondary) *Myocardial Infarction*(duration) yrs. mos. ds. *10*

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *No*What test confirmed diagnosis? (Signed) *Clayton M. Neill* M. D.1-31, 1922 (Address) *Municipal Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Western*DATE OF BURIAL *Feb 2 1922*20 UNDERTAKER *Wm. Cook*ADDRESS *502 E. North*



**WILLIAM COOK**

**FUNERAL DIRECTOR**

**100 NORTH AND GREENMOUNT AVENUES**

LIMOUSINES  
MOTOR HEARSE  
AUTO AMBULANCES  
FUNERAL PARLORS  
EMBALMERS  
CREMATION

BALTIMORE, MD.

Dr. C. Hampson Jones,  
Health Commissioner, Baltimore City.

Sir,

I, the undersigned, do affirm that I am the sister of the late Mrs. Rebecca Phillips who died at Bay View Hospital on the 30th day of January 1922, and that as she was born on the 22nd day of April, 1838 her age is 83 Years, 9 Mos. and 8 days instead of 45 Years as certified by Bay View Hospital.

Very truly yours,

*Sallie E. Davis*

DEPARTMENT OF CHARITIES AND CORRECTIONS  
SUB-DEPARTMENT  
SUPERVISORS OF CITY CHARITIES

MR. HOLLYDAY,  
SUPERINTENDENT  
MR. CURRY,  
ASST. SUPERINTENDENT



**BAY VIEW HOSPITAL**  
HIGHLANDTOWN P. O.

February 13, 1922

To Whom It May Concern: -

This is to certify that I have no personal knowledge of the age of Rebecca Phillips, who, died at this hospital January 30, 1922. The patient who was perfectly rational at the time gave her age as 45. She looked considerably older. The undertaker William Cook reports that she was born April 22, 1838. No autopsy was done and consequently we had no data with which to determine her probable age other than the general appearance. She appeared to be at least 60 years old.

*Clyde McNeil*  
Resident Physician.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60886

D 60886

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No) Municipal Tuberculosis Hospital 8 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Herminau

(a) RESIDENCE. NO. 714 Luzerne ave.

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day. hrs. or min.
35				

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Maryland

10 NAME OF FATHER Adolph Herminau

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Germany

12 MAIDEN NAME OF MOTHER Caroline Myers

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Germany

14 Informant Hospital Records

N.T.H.

15 FEB 2 - 1922

ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31, 1922

17 I HEREBY CERTIFY, That I attended deceased from  
Jan. 19, 1922, to Jan. 31, 1922,  
that I last saw him alive on Jan. 31, 1922,  
and that death occurred, on the date stated above, at 9.30 p. m.  
The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY Tuberculous broncho-  
(Secondary) pneumonia (duration) yrs. mos. 12 ds.18 Where was disease contracted  
if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy? YES

What test confirmed diagnosis? T.B. in sputum, X-ray  
(Signed) J. H. H. M. D.

2-1-22 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Bachmans. Cem.

DATE OF BURIAL

Feb. 4, 1922

20 UNDERTAKER

William Cook

ADDRESS

502 E. North

CAUSE OF DEATH in plain terms, so that it may be understood by the jury. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60887

D 60887

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1422 Reynolds ST. 24 WARD)

## 2-FULL NAME

Viola Q. Popa.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1422 Reynolds

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 16, 1922

7 AGE

Years

Months

Days

17

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto md.

10 NAME OF FATHER

Leonard Popa.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Romania

12 MAIDEN NAME OF MOTHER

Christina Andrie

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto Md.

14

Informant

(Address)

Christina Popa.

1422 Reynolds ST.

FEB 2 - 1922

Filed

Burial Permit Clerk

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 28, 1922, to Feb. 1, 1922.

that I last saw him alive on Jan 31, 1922

and that death occurred, on the date stated above, at 2:15 P.m.

The CAUSE OF DEATH\* was as follows:

Atelectasis

(duration) yrs. mos. 15 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed)

Thos F. Sturms M. D.

2/2, 1922 (Address)

2878 Harford Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

Wm Coole

DATE OF BURIAL

2-3- 1922

ADDRESS

502C N. 4th.



D 60888

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

D 60888  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5106 Medwood Ave ST.; 27 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 5106 Medwood Ave

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 1 yrs., 3 mos. ds)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

Female

## 4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)  
Widow

## 6-DATE OF BIRTH,

September 29, 1860  
(Month) (Day) (Year)

## 7-AGE,

61 yrs., 4 mos., 4 ds.

If LESS than 1 day,

...hrs. or ...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,  
(State or Country),

## 10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

## 12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FEB 2 - 1922

ROBERT R. KRAUTER,

Burial Permit

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

February 1, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 23 1911, to February 1 1922, that I saw him alive on January 31 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Coronary artery of left heart  
arteriosclerosis of heart, lungs, kidney,  
and mesenteric  
(Duration) 25 yrs., 11 mos., 4 ds.CONTRIBUTORY  
(Secondary)

(Duration) 10 yrs., 11 mos., 4 ds.

(Signed) G. W. Bishop M. D.

Feb. 1, 1922 (Address) 502 E. North Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. 15 ds. State yrs. 3 mos. ds.

Where was disease contracted, if not at place of death? Madison, Wisconsin.

Former or usual residence Louisville, Kentucky

## 19-PLACE OF BURIAL OR REMOVAL,

Richmond, Kentucky

## 20-UNDERTAKER

Wm. Cook

## DATE OF BURIAL,

Feb. 2/22 1922

## ADDRESS

502 E. North Ave.

CAUSE OF DEATH. See instructions on back of certificate. important.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60889

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2131 Bolton St. ST., 13 WARD)

## 2. FULL NAME

Pamela B. Wright

## (a) RESIDENCE NO.

2131 Bolton St.

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 10 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mark W. Wright

6 DATE OF BIRTH (month, day, and year) March 17<sup>th</sup> 18567 AGE Years Months Days If LESS than 1 day, hrs. or min.  
65 10 13

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER Jacob G. Baitzell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Hartman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Mark W. Wright (Address) 2131 Bolton St.

15 FEB 2-1922

ROBERT R. KRAUTER, Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30<sup>th</sup> 192217 I HEREBY CERTIFY, That I attended deceased from Nov 8<sup>th</sup> 1921 to Jan 30<sup>th</sup> 1922, that I last saw her alive on Jan 30, 1922, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH\* was as follows:

Sarcoma (region, cervix, uterine)

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Dec 15-1921

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Marshall S. Smith, M. D. Jan 31<sup>st</sup> 1922 Address 118 N Calhoun St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

London Park Cem Feb 2<sup>nd</sup> 1922

20 UNDERTAKER

Joseph B Cook ADDRESS 403 N. Ball St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31D 60890

60890

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 William ST. 7 WARD)

## 2-FULL NAME

(a) RESIDENCE. NO. 1623 William ST. 7 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds.

(If nonresident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	col.	Married
5a If married, widowed, or divorced		
HUSBAND of Maggie Anderson		
6 DATE OF BIRTH (month, day, and year)		
7 AGE		
8 OCCUPATION OF DECEASED		
(a) Trade, profession or particular kind of work		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		
9 BIRTHPLACE (city or town) (State or country)		
10 NAME OF FATHER		
11 BIRTHPLACE OF FATHER (city or town) (State or country)		
12 MAIDEN NAME OF MOTHER		
13 BIRTHPLACE OF MOTHER (city or town) (State or country)		

## PARENTS

14 Informant (Address)	15
1623 William ST. 7 WARD	

FEB 2 - 1922

ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1922

17 I HEREBY CERTIFY, That I attended deceased from 26 Dec. 1921 to Jan. 31 1922 that I last saw him alive on Jan. 31 1922 and that death occurred, on the date stated above, at 2:00 a. m. The CAUSE OF DEATH\* was as follows: Pulmonary Tuberculosis

## CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death? Baltimore, Md.

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed)

1922 (Address) 420 N. Caroline St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Laurel Cemetery

20 UNDERTAKER

Sam. M. Chase - son

DATE OF BURIAL

2/2/22

ADDRESS

1400. Asher

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60891

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital* *monument & Rutland Ave.* *6* WARD)2-FULL NAME *Mrs. Reta Robinson*(a) RESIDENCE NO. *1901 Orleans*

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *3* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*female*

## 4 COLOR OR RACE

*white*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*married*

## 6a If married, widowed, or divorced

HUSBAND of (or) WIFE of

*Howard Robinson*6 DATE OF BIRTH (month, day, and year) *Feb. 16 - 1903*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*18* *11* *15*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*H. W. 037*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

*Deal's Island Md.*10 NAME OF FATHER *Samuel Parkinson*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Deal's Island Md.*12 MAIDEN NAME OF MOTHER *Mamie White*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Deal's Island Md.*

## 14

Informant

(Address)

*Howard Robinson**712 W. Lakewood Ave.*

## 15

*FEB 2 - 1922*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan. 31, 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*Jan. 29, 1922* to *Jan. 31, 1922*that I last saw her alive on *Jan. 31, 1922*and that death occurred, on the date stated above, at *10:00 P. M.*

The CAUSE OF DEATH\* was as follows:

*Intestinal obstruction*

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

*abdominal adhesions*

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? *yes* Date of *Jan. 30, 1922*

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Louis Sachs* M. D.

(Address)

*27-122 The Hebrew Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

*Deal Island Md.*

## 20 UNDERTAKER

*H. Sander Lous*

## DATE OF BURIAL

*Feb. 2, 1922*

## ADDRESS

*1710 Fleet St.*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.



D 60892 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 Clift View Ave ST., 8 WARD)

## 2. FULL NAME

(a) RESIDENCE No. 1711 Clift View Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Catherine Schammel

6 DATE OF BIRTH (month, day, and year) July 23, 1885

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

36 6 9

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Knabe &amp; Co.

9 BIRTHPLACE (city or town) Balto Md. (State or country)

10 NAME OF FATHER George Schammel

11 BIRTHPLACE OF FATHER (city or town) Balto Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary Schwartz

13 BIRTHPLACE OF MOTHER (city or town) Balto Md. (State or country)

14 Informant Christian Schammel (Address) 1711 Clift View Ave

15 Filed FEB 2 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1, 1922

17 I HEREBY CERTIFY, That I attended deceased from

Jan. 1st, 1922, to Feb. 1st, 1922, that I last saw him alive on Jan. 31st, 1922,

and that death occurred, on the date stated above, at 2:00 A. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY Cardiac Failure (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert S. Kirk, M. D.

Address 3126 Harford Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

1st Evangelical Cem. Feb 4, 1922

20 UNDERTAKER ADDRESS

H. Sander Sons 1700 East St.

CAUSE OF DEATH IN plain terms, so that the TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60893

## CERTIFICATE OF DEATH.

31 D 60893

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2410 Fair Ave ST., 1 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

William H. Boblitz

## (a) RESIDENCE NO.

2410 Fair Ave ST.,

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofMary E. Boblitz6 DATE OF BIRTH (month, day, and year) Oct 20, 18567 AGE Years Months Days If LESS than 1 day, hrs. or min.  
65 3 10

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Md.10 NAME OF FATHER Wm. H. Boblitz11 BIRTHPLACE OF FATHER (city or town) P. g.  
(State or country)12 MAIDEN NAME OF MOTHER Louise Dailey13 BIRTHPLACE OF MOTHER (city or town) P. g.  
(State or country)

14

Informant Harry Boblitz  
(Address) 2410 Fair Ave

15

FEB 2 - 1922

Burial Permit ROBERT H. KRAUTER

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 192217 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1922, to Jan. 30, 1922, that I last saw him alive on Jan. 30, 1922, and that death occurred, on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Bronchitis  
(Probably Tubercular)  
(duration) Indefinite yrs. mos. ds.CONTRIBUTORY Terminal Pneumonia  
(Secondary) (duration) yrs. mos. ds. 418 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry D. Atthey, M. D.131, 1922 (Address) 2504 20th St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mount Carmel Cem.

20 UNDERTAKER

H. Sander Sours

DATE OF BURIAL

Feb. 5 1922

ADDRESS

1710 Fleet St.

CAUSE OF DEATH IN plain terms, so far as possible, on back of certificate. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

60894

## CERTIFICATE OF DEATH.

141 D 60894

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 141 D 60894) ST. 1 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

## (a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ST.

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

William Bobbitt

## 6 DATE OF BIRTH (month, day, and year)

Dec 23-1897

## 7 AGE

Years

Months

Days

If LESS than

64

1

9

1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Baltimore Md.

## 10 NAME OF FATHER

Casper Cremer

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Mary Bobbitt

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

## 14

Informant

(Address)

JOHNS HOPKINS HOSPITAL

## 15

Filed

19

FEB 2-1922

ROBERT E. KRAUTH

Registrar

Social Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1<sup>st</sup> 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan. 6<sup>th</sup>, 1922, to Feb. 1<sup>st</sup>, 1922that I last saw her alive on Feb. 1<sup>st</sup>, 1922

and that death occurred, on the date stated above, at 2:20 P.M.

The CAUSE OF DEATH\* was as follows:

Septicemia (Staph. aureus)  
Pt. had complete prolapse uteri, 2 smallulcers before admis. Was operated on 4 days later  
developed renewed abscesses, then multiple abscesses  
(duration) yrs. mos. 1.0 ds.CONTRIBUTORY Perineal abscess  
(Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? yes Date of Jan 14<sup>th</sup> 1922

Was there an autopsy? no

What test confirmed diagnosis? Blood culture

(Signed) Warfield M. Fieror, M. D.

. 19 (Address) Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mount Carmel bur.

## DATE OF BURIAL

Feb. 5 1922

## 20 UNDERTAKER

H. Sander Sours

## ADDRESS

1710 Fildes St.

CAUTION is very important. See instructions on back of certificate.





## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

D 60896

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Hospital ST. 18 WARD)2-FULL NAME Bertie Williams(a) RESIDENCE. NO. 916 W. Lombard St.ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced (write the word)

Unknown

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Unknown

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Virginia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Unknown

14

Informant  
(Address)Hospital Records,  
Municipal Hospital.

15

FEB 2 - 1922 ROBERT A. KRAUTER  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30 1922

17

I HEREBY CERTIFY, That I attended deceased from  
January 21, 1922, to January 30, 1922.

that I last saw her alive on January 29, 1922.

and that death occurred, on the date stated above, at 8:00 A.M.

The CAUSE OF DEATH was as follows:

Syphilis; Cerebrospinal syphilis  
Chronic nephritis.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed)

Clyde McNeil

M. D.

1/30/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Commissioner Health,

FEB 2 1922

PER. W. H. WOODALL

TION is very important. See instructions on back of certificates.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH **D 60897**

REGISTERED NO.

CITY OF BALTIMORE: (No. **Municipal Hospital**

ST.: **26** WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME **Henson Gross**

(a) RESIDENCE. NO. **Unknown**

ST.: WARD.

(Usual place of abode) **about 40** yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Male** 4 COLOR OR RACE **Black** 5 Single, Married, Widowed, or Divorced (write the word) **Widowed**

5a If married, widowed, or divorced HUSBAND of (or) WIFE of **Unknown**

6 DATE OF BIRTH (month, day, and year) **1861**

7 AGE Years Months Days If LESS than 1 day, hrs. or min. **60 -- --**

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work **Laborer**

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) **Calvert Co., Maryland**

10 NAME OF FATHER **Ben Gross**

11 BIRTHPLACE OF FATHER (city or town) **Calvert Co., Maryland**

12 MAIDEN NAME OF MOTHER **Mariah Parker** 1/30/22 (Address) **Municipal Hospital.**

13 BIRTHPLACE OF MOTHER (city or town) **Calvert Co., Maryland**

14 Informant **Hospital Record,** (Address) **Municipal Hospital.**

15 Filed **19** **ROBERT R. KRAUTER**

**FEB 2 - 1922**

Burial Permit Clerk.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) **Jan. 28 1922**

17 I HEREBY CERTIFY, That I attended deceased from **January 27, 1922, to January 28, 1922.** that I last saw him alive on **January 28, 1922.** and that death occurred, on the date stated above, at **10:20 A.M.**

The CAUSE OF DEATH\* was as follows:

**Pneumonia**

(duration) yrs. mos. ds. **7**

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) **Clayton McNeil** M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

**JOHNS HOPKINS HOSPITAL**

**FEB 2 1922**

20 UNDERTAKER **Commissioner Health,**

ADDRESS

Per. Wm. E. Woodall

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE  
D 60898

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bay View Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.: WARD)

2-FULL NAME

John Bennett.

(a) RESIDENCE. NO.

Unknown

ST.: WARD.

(Usual place of abode)

Unknown

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1860

7 AGE

62

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

DO

12 MAIDEN NAME OF MOTHER

DO

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

DO

14

Informant (Address)

Bay View Hospital Baltimore, Md.

15

Filed

FEB 2 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan. 30, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 3

1921, to

Jan 30, 1922

that I last saw him live on

Jan. 30, 1922

and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH\* was as follows:

Septicemia (Streptococcus)

CONTRIBUTORY (Secondary) Cellulitis

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Clinical findings

(Signed) H. Goldsmith, M. D.

1/31/1922 Address Bay View Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

FEB 2 - 1922

20 UNDERTAKER

Commissioner Health,

ADDRESS

Per. Wm. E. WOODALL

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

Source or  
Cause of infection  
unknown.



D 60899

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1524 N. Caroline

ST.:

WARD) 9

2-FULL NAME

Louise Hesse

(a) RESIDENCE. NO.

1524 N. Caroline

ST.:

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 61 yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Henry Hesse

6 DATE OF BIRTH (month, day, and year) Nov. 16, 1829

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

92

2

15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER ----- Deal

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mrs. Louise Akers

1524 N. Caroline St

15

FEB 2 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

15 DATE OF DEATH (month, day, and year) Jan 31 1922

17

HEREBY CERTIFY, That I attended deceased from Jan 13, 1922, to Jan 31, 1922.

that I last saw him alive on Jan 30, 1922.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Fracture of femur

(duration)

yrs. mos. 18 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Walter M. White, Jr.

2/1, 1922 (Address)

2800 St Paul St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Loudon Park Cemetery

DATE OF BURIAL

2/1 1922

ADDRESS

20 UNDERTAKER

Henry W. Mears &amp; Son 805 N. Calvert

[Approved by U. S. Census and American Public Health Assn.]

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of*..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

Accidental fall down step  
By Irene.  
O.K. J. V. Darley. m  
Cramer

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60900

## CERTIFICATE OF DEATH.

D 60900

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 Jackson ST.: 24 WARD)

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Snyder(a) RESIDENCE. NO. 1806 Jackson ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female white 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) married5a If married, widowed, or divorced, HUSBAND of (or) WIFE of John C Snyder6 DATE OF BIRTH (month, day, and year) Jan 26, 18477 AGE Years 75 Months 0 Days 5 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore10 NAME OF FATHER John Albretton

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

## PARENTS

14 Informant (Address)

Frank H. Snyder  
1806 Jackson St.

## 15

FEB 2 - 1922

Burial Permit Blank

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1, 192217 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1921, to Feb 1, 1922, that I last saw her alive on Feb 1, 1922, and that death occurred, on the date stated above, at 2:15 P.M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of stomach(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical signs(Signed) Sidney H. Stettin M. D.  
1/1, 1922 (Address) 405 N. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cedar Hill Feb 8/22

20 UNDERTAKER

ADDRESS

Wm Cook 505 E. York

TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60901

## CERTIFICATE OF DEATH.

49

D 60901

1-PLACE OF DEATH

Union Memorial Hospital

REGISTERED NO.

CITY OF BALTIMORE: (NO.

1514 Division St.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Robert Reese Lloyd

(a) RESIDENCE. NO.

1603 Park Ave.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Annie E. Lloyd

6 DATE OF BIRTH (month, day, and year)

Dec. 16, 1844

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

73

1

15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Merchant 44

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Robt. R. Lloyd

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Eliza Lane Reese

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant

(Address)

Robt. R. Lloyd  
1809 Thomas Ave

15

File

FEB 2-1922

ROBERT R. KRAUTER  
Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

7/1

1922

17

I HEREBY CERTIFY, That I attended deceased from

Dec. 21, 1921, to Feb 1, 1922,

that I last saw him alive on Feb 1, 1922,

and that death occurred, on the date stated above, at 11:14 p. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma, primary in rt. kidney.  
Metastases to lungs & pleura.

(duration) yrs. 2 + mos. ds.

CONTRIBUTORY (Secondary)

Cardiac failure

(duration) yrs. 1 1/2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Thoracentesis

(Signed) George E. W. Hardy, M. D.

19 Address Union Memorial Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Olivet Cem. Feb 4, 1922

20 UNDERTAKER

ADDRESS

Wm Cook, 502 E. North Ave.

TION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60902

## CERTIFICATE OF DEATH.

D 60902

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 N Collington ST.; 15 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. 1510 N Collington ST., WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 1 yrs.  mos.  ds. How long in U. S., if of foreign birth? 1 yrs.  mos.  ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) married5a If married, widowed, or divorced HUSBAND of (or WIFE of) Jennie Pethman6 DATE OF BIRTH (month, day, and year) 18637 AGE 58 Years Months Days If LESS than 1 day,  hrs. or  min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)10 NAME OF FATHER Henry Pethman11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Magdalena Pethman13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)14 Informant Jennie Pethman (Address) 1510 N. Collington15 FEB 2 - 1922 ROBERT R. KRAUTER Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 19 2217 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1922, to Feb 1, 1922, that I last saw him alive on Feb 1, 1922, and that death occurred, on the date stated above, at 10:20 a.m.  
The CAUSE OF DEATH\* was as follows:Pulmonary tuberculosis  
(duration) several yrs.  mos.  ds.CONTRIBUTORY Laryngeal ulcer (T.B.)  
(Secondary) (duration) 1 yrs.  mos.  ds.18 Where was disease contracted not known  
If not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis none  
(Signed) Leonard C. Beach M. D.  
19 (Address) 2231 St Paul St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Feb 3 19 2220 UNDERTAKER Robert Krauter ADDRESS 1510 N. Collington

TION is very important. See instructions on back of certificates.

D 60903 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60903

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1743 Carroll ST., 9 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Martin D. Mangke(a) RESIDENCE NO. 1743 Carroll ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? 45 yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of Anna E. Mangke (or WIFE OF)6 DATE OF BIRTH (month, day, and year) Nov. 7 18857 AGE Years 66 Months 2 Days 26 If LESS than 1 day, .... hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retiree 083(b) General nature of industry, business, or establishment in which employed (or employer) Committee

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)10 NAME OF FATHER Not Known11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)12 MAIDEN NAME OF MOTHER Not Known13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)14 Informant Mrs. Anna E. Mangke(Address) 1743 Carroll St.15 FEB 2 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1<sup>st</sup> 192217 I HEREBY CERTIFY That I attended deceased from Sept 15, 1921 to Feb 1, 1922 that I last saw him alive on Jan 31, 1922and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH\* was as follows:

Organic Heart Disease(duration) 1 yrs. 1 mos. ds.CONTRIBUTORY Sarcoma Kidney (Secondary)(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) Frederick J. Kunze, M. D.21. 1922 (Address) 2700 Harford Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOV. DATE OF BURIALOakview CemeteryFeb 3<sup>rd</sup> 1922

20 UNDERTAKER

Henry Hoeck Son

ADDRESS

1307 E. Eager

CAUSE OF DEATH is very important. See instructions on back of certificates.

D 60904

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60904

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (N

ST. 10 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. - mos.

ST. WARD. (If nonresident give city or town and State) ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Not Known

7 AGE

About 52

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Fireman at 086

(b) General nature of industry, business, or establishment in which employed (or employer)

Westport Power House

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Samuel McComb

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Nancy Lamb

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14 Informant (Address)

Mrs Anna McComb 734 Harford Ave.

15 Filed

FEB 2 - 1922

ROBERT R. KRAUTER Registrar Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 31 1922, to Feb 1 1922, that I last saw him alive on Feb 1 1922, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH\* was as follows:

Acute intestinal obstruction

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. S. Hornstein M. D.

(Address) 733 Airquitt St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore Cemetery

DATE OF BURIAL Feb 4 1922

20 UNDERTAKER

Henry Horch Sun

ADDRESS 1301 E Eppes St

D 60905

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

D 60905

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 615 Dumbarton St.)

## 2-FULL NAME

(Residence in Baltimore: No. 615 Dumbarton

WARD) 9

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. (da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

Feb

20

1864

(Month)

(Day)

(Year)

7-AGE,

57

yrs.

11

mos.

10

da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Lawyer

040

9-BIRTHPLACE, (State or Country).

Baltimore Md

10-NAME OF FATHER,

James Pratt

11-BIRTHPLACE OF FATHER (State or Country).

Baltimore Md

12-MAIDEN NAME OF MOTHER

Elizabeth Currier

13-BIRTHPLACE OF MOTHER (State or Country).

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. Alice Pratt

(Address)

1213 N. Chesapeake

15

FEB 2 - 1922 ROBERT R. KRAUTER,

Filed

191

Burial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Jan

31

1912

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed)

M. D.

(Coroner)

2-2-1912 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

Baltimore County

DATE OF BURIAL,

Feb 5, 1922

20-UNDERTAKER

Henry Horch Sr

ADDRESS

1301 E Bay



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60906

D 60906

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

120 Overland ave

ST.

WARD) 27

## 2. FULL NAME

Bertrude Korfgen

(a) RESIDENCE NO.

120 Overland ave

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 9 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced

(or) WIFE of the late Clemons Korfgen

6 DATE OF BIRTH (month, day, and year)

April 4<sup>th</sup> 1870

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

51

9

27

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife of

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Peter Esselman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Katherine Foos

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Clemons Korfgen 1332 N. Caroline

82-1022

Robert P. Harrison,

19

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 31 1922

17

HEREBY CERTIFY, That I attended deceased from

Jan 31 1922, to Jan 31 1922

that I last saw him alive on

Jan 25 1922

and that death occurred, on the date stated above, at 7 A. M.

The CAUSE OF DEATH\* was as follows:

Coronary Embolism or  
Aortic Embolism or  
Angina Pectoris (Probably)

CONTRIBUTORY (Secondary)

Arterio Sclerosis and Increased Arterial Tension

18 Where was disease contracted if not at place of death?

Did an operation precede death? 0 Date of

Was there an autopsy? 0

What test confirmed diagnosis? 0

Signed) Clara Smith M. D.

1/31/1922 Address) 4706 - Harford Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Western Cemetery

20 UNDERTAKER

George Schilling &amp; Sons

DATE OF BURIAL

Feb 3<sup>rd</sup> 1922

ADDRESS

1126 E. Monument

D 60907 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60907

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1025 Ashland ave ST., 10 WARD)

## 2. FULL NAME

(a) RESIDENCE NO. 1025 Ashland ave ST., 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced

HUSBAND or WIFE of

Arthur Murray6 DATE OF BIRTH (month, day, and year) Unknown7 AGE Years Months Days If LESS than 1 day, hrs. or min. about 90

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland10 NAME OF FATHER Larry Hegerty11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland12 MAIDEN NAME OF MOTHER Sallie Smith13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14

Informant (Address) Miss Mary A Murray  
1025 Ashland ave  
Baltimore, Md.

2-1922

15 2-1922 19 Public Permit Clerk, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1922

17

I HEREBY CERTIFY, that I attended deceased from

Jan 1 1920 to Feb 1 1922.that I last saw her alive on Jan. 29 1922.and that death occurred, on the date stated above, at 7:4 m.

The CAUSE OF DEATH\* was as follows:

Cancer of Uterus.  
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) J. E. Ryan(Address) 1521 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral Cemetery

20 UNDERTAKER

George Schilling & Sons

DATE OF BURIAL

Feb 3<sup>rd</sup> 1922

ADDRESS

1126 E. Monument

CAUSE OF DEATH is very important. See instructions on back of certificates.

# HEALTH DEPARTMENT—CITY OF BALTIMORE D 60908

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)  
Length of residence in city or town where death occurred

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15

1922

Robert P. Harrison

Registrar

Permit Clerk

WARD)

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

ST., WARD.

(If nonresident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-1 1922

17 I HEREBY CERTIFY, That I attended deceased from

2-31, 1922, to 2-1, 1922,

that I last saw him alive on 2-1, 1922,

and that death occurred, on the date stated above, at 10:30 p. m.

The CAUSE OF DEATH\* was as follows:

Meningococcus Meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Lumbar puncture

(Signed) Horace G. Stewart, M. D.

1/2, 1922 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Johns Hopkins Hospital

2-2 1922

20 UNDERTAKER

ADDRESS

Jack Lewis, 414 E. Baltimore

D 60909

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60909

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *76* ST. *76* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Catharine Chan*

## (a) RESIDENCE. NO.

*8502 Mueller*

ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

*Unknown 10 years*ds. How long in U. S., if of foreign birth? *35* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Married*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*1869*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*54**?**?*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife 037*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Germany*

## 10 NAME OF FATHER

*unknown*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*

## 12 MAIDEN NAME OF MOTHER

*unknown*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*

## 14

Informant (Address)

*JOHNS HOPKINS HOSPITAL*

## 15

Filed

19

Serial Permit Clerk.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *1-81* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from *1-80*, 19*22*, to *1-81*, 19*22*,that I last saw him alive on *1-31-22*, 19and that death occurred, on the date stated above, at *4:45* p.m.

The CAUSE OF DEATH\* was as follows:

*Central Hemorrhage*(duration) yrs. mos. *11* ds.

## CONTRIBUTORY (Secondary)

*Pulmonary edema*(duration) yrs. mos. *11* ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

## What test confirmed diagnosis?

(Signed) *E. Bowles Andrew*, M. D., 19 (Address) *Johns Hopkins Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Sacred Heart Cem*

## DATE OF BURIAL

*Feb 4 1922*

## 20 UNDERTAKER

*Lilly Geo Zulu*

## ADDRESS

*4038 Maple*

TION is very important. See instructions on back of certificate.



D 60910

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60910

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *518 N. Becker Ave.* ST., *7* WARD)

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred *20* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Jan. 29 - 1902*

7 AGE

*20*

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*

10 NAME OF FATHER

*John Schlauch*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balto. Md.*

12 MAIDEN NAME OF MOTHER

*Barbara Schubert*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balto. Md.*

14

Informant (Address)

*Barbara Schlauch 518 N. Becker Ave.*

15

Filed

*Robert P. Harrison*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jan. 31 1922*17 I HEREBY CERTIFY, That I attended deceased from *Aug 26*, 19*20*, to *Jan 31*, 19*22*, that I last saw her alive on *Jan 30*, 19*22*, and that death occurred, on the date stated above, at *2.50 P.* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Valvular Endocarditis*

CONTRIBUTORY (Secondary)

(duration) *6* yrs. mos. ds.*Chronic Rheumatism*(duration) *14* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *none*Was there an autopsy? *none*

What test confirmed diagnosis?

(Signed)

*B. P. Herzog md.* M. D.*2/2*, 19*22* (Address) *1305 N Patterson Park Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Manner and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Holy Redeemer Ch.*

DATE OF BURIAL

*Feb 3 1922*

20 UNDERTAKER

*Lilly Geo Ziller*

ADDRESS

*403 S. Broadway*

CAUSE OF DEATH in plain terms, so that it can be understood by laymen. See instructions on back of certificates.

82-1922

D 60911

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60911

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Robert Garrett Hospital for Children

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 27 N. Carey

ST.: 18 WARD)

2-FULL NAME

Berkeley Lorraine Steigman

(a) RESIDENCE, No. 1095 W. Fayette

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If nonresident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year)

Feb 20 1922

7 AGE

Years

3

Months

12

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Raymond Steigman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Rosalie Duffy

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Inferment (Address)

1095 W. Fayette St.

Residence

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

February 19 1922

17

I HEREBY CERTIFY, That I attended deceased from January 1<sup>st</sup> 1922, to February 1<sup>st</sup> 1922, that I last saw her alive on February 1<sup>st</sup> 1922, and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Hydrocephalus &amp; Spina Bifida

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death? no Date of

Was there an autopsy?

yes

What test confirmed diagnosis?

Physical Findings

(Signed)

2/2, 1922 Address)

27 N. Carey

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Olivet Cemetery

Feb 3 1922

20 UNDERTAKER

E. W. Banklin 524 E. Ave

2-1922

Baltimore

D 60912

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60912

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Aged Women Home* ST. *19* WARD)

## 2-FULL NAME

*Martha E. Curry*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. *1400 W. Lexington* ST. *19* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. *0* mos. *0* ds.How long in U. S., if of foreign birth? *0* yrs. *0* mos. *0* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *W.C.T.*5 Single, Married, Widowed, or Divorced (write the word) *Wid*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *unknown*6 DATE OF BIRTH (month, day, and year) *Aug 12, 1819*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. *102* *5* *19*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Baltimore*9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *Eliza Galloway*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ind.*12 MAIDEN NAME OF MOTHER *Charity Carroll*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Harford Co. Ind.*

14

Informant (Address) *Ulla J. Jones*  
*M. Abram*

15

*Robert F. Harrison,*

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 1* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *Jan 15*, 19 *22*, to *Feb 1*, 19 *22*, that I last saw him alive on *Feb 1*, 19 *22*, and that death occurred, on the date stated above, at *5 P.* m.

The CAUSE OF DEATH\* was as follows:

*Altharoma Heart & Aorta*(duration) *2* yrs. *0* mos. *0* ds.

CONTRIBUTORY (Secondary)

(duration) *1* yrs. *0* mos. *0* ds.18 Where was disease contracted if not at place of death? *No*Did an operation precede death? *No*Date of *No*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. H. Woodward*, M. D.19 (Address) *939 W. Fayette*

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Prandon Park**Feb 3, 1922*

20 UNDERTAKER

ADDRESS

*George J. Smith**1000 W. Fayette*

CAUSE OF DEATH IN PARTICULARS. See instructions on back of certificates. TION is very important.

D 60913

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60913

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5201 Ardmore Ave. Govans St.; 27 WARD)

## REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlotte J. West

(Residence in Baltimore: No. 5201 Ardmore Ave. Govans St.; -- yrs., 6 mos. 8 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, July 24, 1921 (Month) (Day) (Year)

7-AGE, 6 yrs., 6 mos., 8 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore, Maryland

PARENTS. 10-NAME OF FATHER, Charles J. West 11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania 12-MAIDEN NAME OF MOTHER, Mabel I. Kellar 13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mabel I. West (Address) 5201 Ardmore Ave., Govans

15-

Filed Robert P. Harrison, Registrar.

2-1922

Serial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 1, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to July 1, 1922, that I saw her alive on July 1, 1922, and that death occurred, on the date stated above, at 5 P. m. The CAUSE OF DEATH\* was as follows:

Double Pneumonia (Duration) ... yrs. ... mos. 3 ... ds.

CONTRIBUTORY (Secondary)

(Signed) E. H. Duncan M. D. July 1, 1922 (Address) 5106 York Road

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the ... yrs. ... mos. ... ds. State ...

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet Cemetery DATE OF BURIAL, 2/3, 1922

20-UNDERTAKER, Henry W. Mears &amp; Son 805 N. Calvert ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60914

## CERTIFICATE OF DEATH.

D 60914

## PLACE OF DEATH

CITY OF BALTIMORE (No. 527 Walnut Alley ST. 17

## FULL NAME

Annis Lewis

(Residence in Baltimore: No.

527 Walnut Alley

## REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

female

## 4-COLOR OR RACE,

colored

## 5-SINGLE,

MARRIED, widowed  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

November, 1889  
(Month) (Day) (Year)

## 7-AGE,

33 yrs. mos. da.

## If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Landress

(b) General nature of industry, business, or establishment in which employed (or employer).

041

9-BIRTHPLACE,  
(State or Country),

Md.

## 10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

## 12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Crowley

(Address) 527 Walnut Alley

## 15-

Filed Robert P. Harrison, Registrar.

Serial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

Jan. 30, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, had that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Myocardial heart disease

(Duration) yrs. mos. da.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. da.

(Signed) J. T. Harrison, M. D.  
(Coroner.)

Jan. 30, 1922 (Address) 2802 E. Churchman

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the  
of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

## Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Mt. Calvary

## DATE OF BURIAL,

Feb. 2, 1922

## 20-UNDERTAKER

Amel Easter

## ADDRESS

R. C.

D 60915 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60915

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 Mc Gulloh ST., 11 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Moranda Taylor

(a) RESIDENCE NO. 1124 Mc Gulloh ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE 54 Years 10 Months 8 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Robert P. Harrison, Registrar

Marial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/31/1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1922, to Jan. 31, 1922.

that I last saw her alive on Jan. 19, 1922.

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH\* was as follows:

Uremia

CONTRIBUTORY

(Secondary)

Chronic Intestinal Nephritis about 10 yrs. 5 mos. 5 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed)

John H. Thompson, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 60916

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60916

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital* WARD)

## 2-FULL NAME

*Herbert Marken*(a) RESIDENCE. NO. *1724 N. Washington St.* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *4* yrs. *2* mos. *22* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*white*

5 Single, Married, Widowed, or Divorced (write the word)

*single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Nov. 10 - 1918*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*4**2**22*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balto. Md.*

10 NAME OF FATHER

*John Marken*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Norway*

12 MAIDEN NAME OF MOTHER

*Eunna Petersen*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Buffalo, N.Y.*

14

Informant (Address)

*John L. Marken 1724 N. Washington St.*

15

Filed

*Robert P. Harrison*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 2 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 27 1922 to Feb 2 1922*that I last saw him live on *Feb. 2 1922*and that death occurred, on the date stated above, at *10:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Diphtheria, tonsillitis, + pharyngeal*(duration) yrs. mos. *9* ds.

CONTRIBUTORY (Secondary)

*Myocarditis*(duration) yrs. mos. *7* ds.18 Where was disease contracted if not at place of death? *at home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Culture pos.*(Signed) *William H. Hays* M. D.*2/2/22* (Address) *Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Baltimore Cem.*

DATE OF BURIAL

*Feb 3 1922*

20 UNDERTAKER

*H. Sander Son*

ADDRESS

*1710 Flat St.*

CAUSE OF DEATH IN plain terms, so that it may be understood by laymen, is very important. See instructions on back of certificates.

82-1922

Permit Clerk.

(Lawrence D. Brent)

D 60917 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60917

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: NO

ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

ST.

WARD.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mrs. L. J. Brent

6 DATE OF BIRTH (month, day, and year)

7-1849

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

73

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

Robert P. Harrison,

Registrar

Mortuary Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 1

1922

17

HEREBY CERTIFY, that I attended deceased from

Jan - 19, 1922, to February 1, 1922, that I last saw him alive on Feb 1 - 1922.

and that death occurred, on the date stated above, at 11:50 a.m.

The CAUSE OF DEATH\* was as follows:

Diffuse Broncho-Pneumonia

CONTINUING DISEASES - (duration) yrs. mos. ds. Colic, enteritis, Cholera - (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? The Plains, Virginia.

Did an operation precede death? 955 Date of

Was there an autopsy? No -

What test confirmed diagnosis? Physical findings -

(Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional instructions.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Marshall Va

Feb 4 1922

20 UNDERTAKER

ADDRESS

Harry H. Witzke

1531 W. Lombard

CAUSE OF DEATH is very important. See instructions on back of certificates.

B2-1922



D 60918

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60918

## CERTIFICATE OF DEATH.

(Union Ave)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 32 Union Ave ST. 75 WARD)

## 2-FULL NAME

(a) RESIDENCE. No. 32 Union Ave ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary R. Kinsey

6 DATE OF BIRTH (month, day, and year) Jan. 9, 1844

7 AGE Years 77 Months 7 Days 22 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

10 NAME OF FATHER Charles Kinsey

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Sarah Higgins

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant (Address) 32 Union Ave

15 Filed

B2-1922

Robert F. Harrison,

Burial Permit Clerk.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1921, to Jan 31, 1922, that I last saw him alive on Jan 28, 1922, and that death occurred, on the date stated above, at 12:40 P. M.

The CAUSE OF DEATH\* was as follows

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) James H. Harrison, M. D.

4/2, 1922 Address 1729 N. Lombard St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Western Cemetery Feb 3 1922

20 UNDERTAKER

Harry H. Witzke 1531 W. Lombard

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60919

## CERTIFICATE OF DEATH.

90 D 60919

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1800 Park Ave* ST. *19* WARD)

## REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Wm. B. Bissell, Baltimore*(Residence in Baltimore: No. *1800 Park Ave* St.: *60* yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*6-DATE OF BIRTH, *Sept. 1, 1851*  
(Month) (Day) (Year)7-AGE, *70* yrs. — mos. — ds. IF LESS than 1 day, ... hrs. or ... min.8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *OOD*  
(b) General nature of industry, business, or establishment in which employed (or employer), *At Home*9-BIRTHPLACE, (State or Country), *Baltimore, Md.*10-NAME OF FATHER, *Wm. J. Bissell*11-BIRTHPLACE OF FATHER (State or Country), *Virginia*12-MAIDEN NAME OF MOTHER, *Margaret Webster*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Clara B. Bissell*(Address), *1800 Park Ave*

15- Robert P. Harrison,

Burial Permit Clerk. Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb. 1, 1922*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 1, 1921* to *Feb. 1, 1922*  
that I saw him alive on *Jan. 31, 1922*  
and that death occurred, on the date stated above, at *12* m.The CAUSE OF DEATH\* was as follows:  
*Organic Heart Disease*  
*Subacute Inflammation*  
(Duration) ... yrs. ... mos. ... ds.CONTRIBUTORY (Secondary) ...  
(Duration) ... yrs. ... mos. ... ds.  
(Signed) *James E. Bissell* M. D.  
*Feb. 2, 1922* (Address) *717 N. W. Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).  
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Anne's, Baltimore, Md.* DATE OF BURIAL, *Feb. 3, 1922*20-UNDERTAKER, *Chas. J. Davis* ADDRESS, *118 N. W. Ave*

CAUSE OF DEATH. See instructions on back of certificate.

B2-1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60920

38 D 60920

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 373 Iceland St.)

2-FULL NAME

(Residence in Baltimore: No. 373 Iceland St.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 37 mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Caucasian

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

Married

6-DATE OF BIRTH,

Oct 8, 1869  
(Month) (Day) (Year)

7-AGE,

52 yrs. 11 mos. 10 ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Letter carrier

9-BIRTHPLACE,  
(State or Country),

Va

10-NAME OF FATHER,

Richard T. Rouzia

11-BIRTHPLACE OF FATHER  
(State or Country),

Va

12-MAIDEN NAME OF MOTHER

Mary J. Spurlock

13-BIRTHPLACE OF MOTHER  
(State or Country),

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie Rouzia

(Address) 513 Iceland St.

15

FEB 3 - 1922 ROBERT R. KRAUTER,

Filed 191 Burial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan 28, 1922  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an autopsy.

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.

autopsy and that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Rupture of Aorta

(Duration) yrs. 11 mos. 10 ds.

CONTRIBUTORY (Secondary) Heart disease

(Duration) yrs. 11 mos. 10 ds.

(Signed) J. L. Brown, M. D.

(Coroner) 14376 Gray

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. 11 mos. 10 ds. State, yrs. 11 mos. 10 ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,

Asbury Ct

DATE OF BURIAL,

Feb 4, 1922

20-UNDERTAKER

J. L. Brown, Son

ADDRESS

108 W. Monty St

CAUSE OF DEATH in plain terms, so that it may be properly entered important. See instructions on back of certificate.

D 60921

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

D 60921

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *17* ST.: *17* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. *621 Orchard* ST., *17* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *20* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? *0* yrs. *0* mos. *0* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of *H. Davis* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *July 15, 1884*7 AGE Years *37* Months *6* Days *16* If LESS than 1 day, *0* hrs. *0* min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Steward*(b) General nature of industry, business, or establishment in which employed (or employer) *074*

(c) Name of employer

9 BIRTHPLACE (city or town) *md.* (State or country)10 NAME OF FATHER *Joseph Davis*11 BIRTHPLACE OF FATHER (city or town) *md.* (State or country)12 MAIDEN NAME OF MOTHER *Lizzie*13 BIRTHPLACE OF MOTHER (city or town) *md.* (State or country)14 Informant *Mersey Hospital* (Address) *Records*

15 FEB 3 - 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 1, 1922*17 HEREBY CERTIFY, That I attended deceased from *Jan 25, 22* to *Feb 1, 22*, that I last saw him alive on *Feb 1, 1922*and that death occurred, on the date stated above, at *12:20 a.m.*

The CAUSE OF DEATH\* was as follows:

*Labar Pneumonia*CONTRIBUTORY (Secondary) *Cardiac Failure* (duration) *0* yrs. *0* mos. *0* ds.18 Where was disease contracted *Home* if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *Findings suggest pneumonia*(Signed) *Wm. L. Brown, M. D.*19 (Address) *Mersey Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*My Auburn Ct* *Feb 3, 1922*

20 UNDERTAKER ADDRESS

*W. L. Brown & Son 101 N. Montz*

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.



# D 60922 HEALTH DEPARTMENT-CITY OF BALTIMORE D 60922

PLACE OF DEATH

CERTIFICATE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 1816 N. Bethel St.)

ST. 8 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Monte Matilda Gilbert

(Residence in Baltimore: No. 1816 N. Bethel

St. 60 yrs. 3 mos. - ds.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

female

4-COLOR OR RACE

white

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widowed

6-DATE OF BIRTH

Nov. 1st, 1860

7-AGE

61 yrs. 3 mos. 2 ds.

If LESS than

1 day, hrs.

min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

Cecil Co. Md.

10-NAME OF FATHER

James Ewing

11-BIRTHPLACE OF FATHER

(State or country)

Maryland

12-MAIDEN NAME OF MOTHER

Caroline Gilbert

13-BIRTHPLACE OF MOTHER

(State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Stanley Gilbert

(Address)

1816 N. Bethel St.

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Jan. 31, 1922

17-I HEREBY CERTIFY, That I attended deceased from Dec 29th, 1921, to Jan 31, 1922

that I saw her alive on Jan 30, 1922 and that death occurred, on the date stated above, at 11 a. m. The CAUSE OF DEATH was as follows:

Chronic Endocarditis  
(By protection -) yrs. mos. ds.  
Contributory Pulmonary Edema  
(SECONDARY)  
(Signed) M. D. 2 mos. 2 ds.  
Feb 1, 1922 (Address) 2847 N. Calver St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.  
Where was disease contracted?  
If not at place of death?  
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Baltimore Center

DATE OF BURIAL

Feb 3, 1922

20-UNDERTAKER

George J. Ruth 1735 H. 2nd St.

FEB 3 - 1922

ROBERT R. KRAUTER,

Burial Permit Registrar

N. B.-Every item of information should be carefully supplied. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

D 60923

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60923

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3626 Greenmount Avenue ST.; 12 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mary Emily Biden

## (a) RESIDENCE. NO.

3626 Greenmount Ave. ST.,

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 4 mos. 9 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

George T. Biden

6 DATE OF BIRTH (month, day, and year) Sept 22, 1872

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
49 4 9

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

Maryland

## 10 NAME OF FATHER Robert Liddell

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

## 12 MAIDEN NAME OF MOTHER Susan E. Bomberger

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Charles E. King (Address) 3626 Greenmount Avenue

15 Filed FEB 3 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/1/ 1922

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1921, to Feb 1, 1922, that I last saw her alive on Feb 1, 1922, and that death occurred, on the date stated above, at 10.30 a.m. The CAUSE OF DEATH\* was as follows:

Pernicious Anæmia -

(duration) 3 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Myocardial Insufficiency (duration) yrs. mos. 1 day

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No -

What test confirmed diagnosis? - Blood Examination (Signed) Chas. R. Goldberger, M. D.

(Address) 2735 N. Charles St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Olivet Cemetery

## DATE OF BURIAL

2/3, 19 22

## 20 UNDERTAKER

Henry W. Mears &amp; Son 805 N. Calvert

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60924

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

34 yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

E. A. Phelps

6 DATE OF BIRTH (month, day, and year)

2/4/1883

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

38

11

26

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Wt.

10 NAME OF FATHER

Robert Ward

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Wt.

12 MAIDEN NAME OF MOTHER

Annabel Phillips

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Wt.

14

Informant  
(Address)

Mrs. Lurie Phelps

1 deceased

15

FEB 3 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 31 1922

17

I HEREBY CERTIFY, That I attended deceased from

1/30, 1922, to 1/31, 1922.

that I last saw her alive on 1/30, 1922.

and that death occurred, on the date stated above, at 12:35 a.m.

The CAUSE OF DEATH\* was as follows:

Femoral Hernia (Intestinal obstruction - Shock - Cardiac Decompression).

(duration) yrs. mos. 7 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted  
if not at place of death?

640 Wt Ave Brooklyn

Did an operation precede death? yes Date of 1/30/22

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical

(Signed)

W. D. Douglas, M. D.

19 (Address)

Maryland General Hospital

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cedar Hill Cemetery

Feb 3 1922

20 UNDERTAKER

ADDRESS

John F. Denny

715 Light

CAUSE OF DEATH IN PLAIN ENGLISH. See instructions on back of certificates. TION is very important.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60925

D 60925

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1299 William* ST. *74* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. *1299 William* ST. WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *72* yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M.* 4 COLOR OR RACE *W.* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug 29, 1849*7 AGE Years Months Days *72* *5* *2* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country)10 NAME OF FATHER *Joe. W. Holmes*11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country)12 MAIDEN NAME OF MOTHER *Mary Z. Williams*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country)14 Informant *Mrs. G. Z. Reight*(Address) *931 B. St. Waverly*15 *FEB 3 - 1922* ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *1. 31. 1922*17 I HEREBY CERTIFY, That I attended deceased from *7-22*, 19*21*, to *1. 31. 22*, 19that I last saw him alive on *1. 31. 22*, 19and that death occurred, on the date stated above, at *10.30 P. m.*

The CAUSE OF DEATH\* was as follows:

*Acute & Fatal Insufficiency*(duration) *5* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *clinical*(Signed) *G. Lilia S. Towler* M. D.(Address) *1432 William St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park Cemetery**Feb. 3 1922*

20 UNDERTAKER

ADDRESS

*John F. Denny**715 Light*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.



D 60926

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60926

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 816 William St. St. 22 Ward)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles W. Vansant.

(Residence in Baltimore: No. 816 William St. St.; yrs. 74 mos. 5 ds. 14)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, (Write the word.) Single.

6-DATE OF BIRTH, August 19th. 1847. 1. (Month) (Day) (Year)

7-AGE, 74 yrs. 5 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Machinist. (b) General nature of industry, business, or establishment in which employed (or employer), 031

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Joshua Vansant.

11-BIRTHPLACE OF FATHER, (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Anna M. Ross.

13-BIRTHPLACE OF MOTHER, (State or Country), Cincinnati, O.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alva V. Brannan. (niece)

(Address) 816 William St.

15- FEB 3 - 1922 ROBERT R. KRAUTER, Serial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 2nd. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Organic disease of the heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) Otto M. Reinhardt M. D. (Coroner)

2/2/22, 1922 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Int Olivet

Feb 3, 1922

20-UNDERTAKER,

ADDRESS

John F. Denny

715 Light St

is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60927

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *2307 Roslyn Ave* ST. *15* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *2307 Roslyn Ave* St.; *9* yrs., — mos. — ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Female*

## 4-COLOR OR RACE.

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

## 6-DATE OF BIRTH.

*Nov. 20*, 18*34*  
(Month) (Day) (Year)

## 7-AGE.

*57* yrs. *2* mos. *11* ds.

If LESS than 1 day.

....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*Retired*

## 9-BIRTHPLACE.

(State or Country), *Md.*

## 10-NAME OF FATHER.

*Joseph Patchett*

## 11-BIRTHPLACE OF FATHER

(State or Country), *Md.*

## 12-MAIDEN NAME OF MOTHER

*Elizabeth Linnamon*

## 13-BIRTHPLACE OF MOTHER

(State or Country), *Md.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Chas. H. Wright*(Address) *2041 Madison Ave*15-*FEB 3 - 1922*

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

*July 1*, 19*22*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan 28* 19*22*, to *Jan 31st* 19*22*, that I saw her alive on *Jan 31st* 19*22*, and that death occurred, on the date stated above, at *10 P.m.*

The CAUSE OF DEATH\* was as follows:

*Heart Hemiplegia*

(Duration).... yrs. .... mos. .... ds.

## CONTRIBUTORY (Secondary)

(Duration).... yrs. .... mos. .... ds.

## (Signed)

*Eugene Douglas* M. D.*July 2*, 19*22* (Address) *835 W. North Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

*Preston Md*

## DATE OF BURIAL.

*Feb 7*, 19*22*

## 20-UNDERTAKER

*Chas. E. French*

## ADDRESS

*835 W. North Ave*

important. See instructions on back of certificate.

# Apoplectic

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

*lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septiciæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

<i>Abortion,</i>	<i>Cellulitis,</i>	<i>Childbirth,</i>	<i>Convulsions,</i>
<i>Hæmorrhage,</i>	<i>Gastritis,</i>	<i>Erysipelas,</i>	<i>Meningitis,</i>
<i>Gangrene,</i>	<i>Miscarriage,</i>	<i>Necrosis,</i>	<i>Peritonitis,</i>
<i>Phlebitis,</i>	<i>Pyæmia,</i>	<i>Septiciæmia,</i>	<i>Tetanus.</i>

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.

D 60928

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60928

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE

ST. 10 WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## WARD.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

30

Years

Months

3

Days

23

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

File

FEB 3 - 1922

ROBERT N. KRAUTER, Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2, 1922

17

I HEREBY CERTIFY, That I attended deceased from 12/15/21 to 2/2/22, 19

that I last saw him alive on 2/2/22, 19

and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH\* was as follows:

Coronary Insufficiency

CONTRIBUTORY (Secondary) (duration) yrs. mon. ds. Michael &amp; Antie Insufficiency

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



D 60929

HEALTH DEPARTMENT CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2306 Boston*ST.: *1*

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Margaret Jozymala*(a) RESIDENCE. No. *2306 Boston*

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Female**white**single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *June 3 1921*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*7**29*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore*

10 NAME OF FATHER

*Felix Jozymala*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Poland*

12 MAIDEN NAME OF MOTHER

*Anna Jurek*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore*

14

Informant (Address)

*Anna Jozymala 2306 Boston St*

15

FEB 3 - 1922

ROBERT S. KRAUTH Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 2 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Jan. 21 1922* to *Feb. 2 1922*, that I last saw her alive on *Feb. 1 1922*, and that death occurred, on the date stated above, at *4 A.M.*

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*

CONTRIBUTORY (Secondary)

duration) yrs. mos. ds. *3*

18 Where was disease contracted if not at place of death?

*At home*

Did an operation precede death?

*No*

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Physical signs*

(Signed)

*C. S. Meier* M. D.

(Address)

*408 S. PATOK Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Polk Rosary**Feb 3**1922*

20 UNDERTAKER

ADDRESS

*John M. Weber**1803 Bank*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60930

## CERTIFICATE OF DEATH.

X 129 D 60930

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No.

1522 Light

ST. 23 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mary E. Farmer

## (a) RESIDENCE. No.

1522 Light

ST. WARD.

Washington DC

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

4

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced (write the word)

Female White

Widowed

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Wm. C. Farmer

## 6 DATE OF BIRTH (month, day, and year)

July 21 1856

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

65

6

12

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Spottsylvania  
Va.

## 10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Va.

## 12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

## 14

Informant  
(Address)

Catherine Farmer

1522 Light St.

## 15

File

FEB 3 - 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb 2 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Nov 5 1921, to Feb 2 1922,

that I last saw him alive on Feb 2 1922,

and that death occurred, on the date stated above, at 6:30 p. m.

The CAUSE OF DEATH\* was as follows:

Chronic interstitial  
nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. &amp; urinary

(Signed) Wm. C. Farmer M. D.

1/2, 1922 (Address) 1519 Light St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Washington DC

2/3/22

## 20 UNDERTAKER

## ADDRESS

Margaret E. Flynn

1422 Light St

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60931

90 D 60931

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 16 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE, No.

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OF RACE C of 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Chase

6 DATE OF BIRTH (month, day, and year)

7 AGE 45 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

FEB 3 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1922

17 I HEREBY CERTIFY, that I attended deceased from Aug 15, 1922, to Jan 29, 1922

that I last saw him alive on Jan 29, 1922, and that death occurred, on the date stated above, at 10:15 p. m.

The CAUSE OF DEATH\* was as follows:

Mitral Insufficiency

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1912 Address

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 60932

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Hebrew Hospital

CITY OF BALTIMORE: (No. 8 Monument

ST., 6

WARD)

2-FULL NAME

Miss Ida Bernstein

(a) RESIDENCE NO.

2208 E. Fairmount Ave.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

17

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

17

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

H4 D 60932

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

X

6 DATE OF BIRTH (month, day, and year)

1897

7 AGE

25

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tailoring

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Joseph Bernstein

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Lena

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Jack Lewis 1411 E. Baltimore St.

15

FEB 3 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 16 1922, to Feb 3 1922, that I last saw her alive on Feb 2 1922, and that death occurred, on the date stated above, at 12:45 a.m.

The CAUSE OF DEATH\* was as follows:

Septicemia  
Pneumonia

CONTRIBUTORY (Secondary) Carcinoma of stomach (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Did an operation precede death? Yes Date of 12/31/22

Was there an autopsy? What test confirmed diagnosis? (Signed) Ernest Edlaortek M. D. Feb 3, 1922 (Address) Hebrew Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Hebrew Home 2-3-1922 ADDRESS 1411 E. Baltimore St. 20 UNDERTAKER Jack Lewis



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60933

## CERTIFICATE OF DEATH.

129 D 60933

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4110-Alto-Ave.

ST.: 15 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Sherwood

(a) RESIDENCE NO. 4110-Alto-Av. ST. 15 WARD. (Resident)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 57 yrs. 0 mos. 1 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Jeanette Hoggson Sherwood

6 DATE OF BIRTH (month, day, and year) Feby-1-1865

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 57 0 1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Editor on

(b) General nature of industry, business, or establishment in which employed (or employer) Staff of American

(c) Name of employer The Baltimore American

9 BIRTHPLACE (city or town) Warren (State or country) Virginia

10 NAME OF FATHER William Sherwood

11 BIRTHPLACE OF FATHER (city or town) Warren (State or country) Virginia

12 MAIDEN NAME OF MOTHER Martha Ellington

13 BIRTHPLACE OF MOTHER (city or town) Warren (State or country) Virginia

14 Informant Mrs. Jeanette H. Sherwood (wife) (Address) 4110-Alto-Av., City

15 FEB 3 - 1922 J. E. McElm Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2 1922

17 I HEREBY CERTIFY, That I attended deceased from

Jan 18 1922, to Feb. 2 1922,

that I last saw him alive on Feb 1 - 1922,

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH\* was as follows:

Myocarditis About 3 wks (duration) yrs. mos. ds.

CONTRIBUTORY Parenchymatous Nephritis (Secondary) from history - about 1 yr (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical - Laboratory Findings

(Signed) W. B. Hiblett M. D. Feb. 2 - 22 (Address) 2220 Garrison St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Woodlawn Cemetery

Feb-4-22

20 UNDERTAKER STEWART &amp; MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS

100 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly transcribed. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60934

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 921 Prince St. ST. 18 WARD)2. FULL NAME Rebecca Noel(a) RESIDENCE NO. 921 Prince St. ST. 18 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 0 mos. 0 ds.How long in U. S., if of foreign birth? 7 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of Jack Robinson (or) WIFE of6 DATE OF BIRTH (month, day, and year) Feb. 2 19227 AGE 78 Years Months Days If LESS than 1 day, 0 hrs. or 0 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Jack Robinson11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)12 MAIDEN NAME OF MOTHER Maria Jones13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14

Informant J. M. Smith (Address) 1024 Druid Hill Ave.

15

Filed FEB 3 - 192219 1922Registrar J. M. Smith

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2 192217 I HEREBY CERTIFY, That I attended deceased from 1-22-22, 19 22, to 2-2-22, 19 22.that I last saw her alive on 2-1-22, 19 22.and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH\* was as follows:

ApoplexyCONTRIBUTORY senility, arterio-sclerosis (duration) 12 yrs. 0 mos. 0 ds. (Secondary) roses (duration) 1 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) F. M. Cardoso M. D. 2-2-22 (Address) 1524 Druid Hill Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 60935

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60935

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 E Fort an ST.; 179 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. 217 E Fort an ST.; 179 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grafton Thompson

6 DATE OF BIRTH (month, day, and year) May 29, 1844

7 AGE 72 Years 8 Months 2 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## PARENTS

## 14

Informant (Address)

## 15

Filed, 19

FEB 3 - 1922

ROBERT S. KRAUTER, Registrar

Serial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1. 31 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 25, 1922, to Jan 31, 1922, that I last saw him alive on Jan 31, 1922, and that death occurred, on the date stated above, at 8: P m.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Grippe

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test (confirmed diagnosis)?

(Signed) A. J. Sullivan, M. D.2.1. 1922 (Address) 102 E Fort an

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Louisa Park Cemetery2/3/ 1922

## 20 UNDERTAKER

## ADDRESS

E. J. Manning & Son - 1460 Battery R.

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

D 60936

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D 60936

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydneyham Hospital*)

## 2-FULL NAME

(a) RESIDENCE. NO. *268 Dulaney*(Usual place of abode)  
Length of residence in city or town where death occurred *6* yrs. *0* mos. *17* ds.

ST.

WARD.

(If nonresident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OF RACE

5 Single, Married, Widowed, or Divorced (write the word)

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Jan 14-1916*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

FEB 3 - 1922

ROBERT R. KRAUTER  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 2 1922*17 I HEREBY CERTIFY, That I attended deceased from  
*Feb. 2 1922 to Feb 2 1922*  
that I last saw him alive on *Feb. 1 1922*  
and that death occurred, on the date stated above, at *2145 P. m.*

The CAUSE OF DEATH\* was as follows:

*Diphtheria, Acute tonsillitis  
and pharyngitis.*CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

*Myocarditis*18 Where was disease contracted  
if not at place of death?*at home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates. TION is very important.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60937

## CERTIFICATE OF DEATH.

90 D 60937

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 325 S Stucker ST.; 19 WARD)2-FULL NAME Rhoda E. Giegler(Residence in Baltimore: No. 325 S Stucker St.; 61 yrs.,  mos.,  ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female4-COLOR OR RACE, White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widow  
(Write the word.)6-DATE OF BIRTH, March 8, 1860

(Month)

(Day)

(Year)

7-AGE, 61 yrs.,  mos.,  ds.If LESS than 1 day,  hrs. or  min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Housework(b) General nature of industry, business, or establishment in which employed (or employer) Housework9-BIRTHPLACE, (State or Country), Balto10-NAME OF FATHER, James Badger11-BIRTHPLACE OF FATHER (State or Country), Balto12-MAIDEN NAME OF MOTHER, Liza Badger13-BIRTHPLACE OF MOTHER (State or Country), Balto

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Jones(Address) 325 S Stucker St

## 15-

FEB 3 - 1922

ROBERT R. KRAUTER,

Burial Permit Clark Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 1, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 25, 1922, to Feb 1, 1922,that I saw her alive on Jan 31, 1922and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH\* was as follows:

Endocarditis(Duration) 1 yrs.,  mos.,  ds.CONTRIBUTORY (Secondary) Coronary Arteriosclerosis(Duration) 1 yrs.,  mos.,  ds.(Signed) John E. Mues M. D.Feb 1, 1922 (Address) 1520 Hollins

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death  yrs.,  mos.,  ds. In the State  yrs.,  mos.,  ds.Where was disease contracted, if not at place of death? Former or usual residence 19-PLACE OF BURIAL OR REMOVAL, London Park CemDATE OF BURIAL, 2-3-192220-UNDERTAKER Robert Brooks & SonADDRESS Cathow

important. See instructions on back of certificate.

(Noble D. Gallup) ✓  
 1235 60938 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60938  
 32  
 CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 18 ST. 18 WARD)

## REGISTERED NO.

(If death occurred in  
 a hospital or institu-  
 tion, give its NAME  
 instead of street and  
 number.)

## 2-FULL NAME

Noble D. Gallup

## (a) RESIDENCE. NO.

212 N. Fremont

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Single

## 6 DATE OF BIRTH (month, day, and year)

3-6-1920

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

1

10

30

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

None

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

None

## (c) Name of employer

None

9 BIRTHPLACE (city or town)  
(State or country)Baltimore  
Md

## 10 NAME OF FATHER

Noble Gallup

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Baltimore  
Md

## 12 MAIDEN NAME OF MOTHER

Dorothy Bondick

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Baltimore  
Md

## 14

Informant  
(Address)

JOHNS HOPKINS HOSPITAL

## 15

Filed

Robert T. HARRISON,

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

2-2-1922

## 17

I HEREBY CERTIFY, That I attended deceased from

1-30, 1922, to 2-2, 1922

that I last saw him alive on 2-2, 1922

and that death occurred, on the date stated above, at 8 A. M.

The CAUSE OF DEATH\* was as follows:

Tuberculosis meningitis

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? The final report = + 1-30-22

(Signed) T. B. Gay, M. D.

, 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

FEB 8-1922

Burial Permit Clerk

D 60939

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60939

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE (No. 528 4 Belvedere St.)

FULL NAME Rada Kankasky

(Residence in Baltimore: No. 528 4 Belvedere

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 5 mos. 6 da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Baby  
6-DATE OF BIRTH, July 5, 1916.  
(Month) (Day) (Year)

7-AGE, 5 yrs. 6 mos. 6 da. IF LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. Infant  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balt

10-NAME OF FATHER, Paul Kankasky

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER, Mary Rets

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul Kankasky

(Address) 528 4 Belvedere St.

15-

Filed, 191.

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 2, 1917.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Burns. state staying

with good food

CONTRIBUTION (Secondary)

(Duration) yrs. mos. da.

(Signed) M. D.

2-2, 1917 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Sole Redeemer Feb 4, 1917

20-UNDERTAKER ADDRESS

Paul Kankasky 1906 Belvedere St.

D 60940

HEALTH DEPARTMENT—CITY OF BALTIMORE, 001

D 60940

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 N Eleventh St., 76 WARD)

## REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Marie Grabau

(Residence in Baltimore: No. 106 N Eleventh St., 35 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

## 6-DATE OF BIRTH.

Aug 31, 1850  
(Month) (Day) (Year)

## 7-AGE.

71 yrs. 5 mos. 11 ds.

If LESS than 1 day.

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Housework at Home

## 9-BIRTHPLACE, (State or Country).

Germany

## 10-NAME OF FATHER.

Unknown

## 11-BIRTHPLACE OF FATHER (State or Country).

Unknown

## 12-MAIDEN NAME OF MOTHER

Unknown

## 13-BIRTHPLACE OF MOTHER (State or Country).

Unknown

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. H. Grabau

(Address) 106 N Eleventh St

## 15-

Robert P. Harrison,

B3-1922

Burial Permit Clerk,

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

Feb 1<sup>st</sup>, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Jan 24 1922, to Feb 1<sup>st</sup> 1922,that I saw her alive on Feb 1<sup>st</sup> 1922,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia  
(Duration) yrs. mos. 9 ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.  
(Signed) Adam Tod M. D.  
, 101... (Address) 4704 Eastern Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

Oak Lawn Cem

## DATE OF BURIAL.

Feb 4, 1922

## 20-UNDERTAKER

Peter Nicolaus

## ADDRESS

2046 Eastern Ave



## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

ST.: 0 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 74  
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed,  
or Divorced (write the word) *Married*

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 1<sup>st</sup> 1922.

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	45	7	1	

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Leather Workings*

(b) General nature of industry, business, or establishment in which employed (or employer) *Leather Hand Bags*

(c) Name of employer Gorman H. Bello

9 BIRTHPLACE (city or town) Boston, Mass.  
(State or country)

10 NAME OF FATHER *Robert T. Hunt,*

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER *Elena M. Dolch.*

13 BIRTHPLACE OF MOTHER (city or town) Dallas, Tex  
(State or country) Tex

10 Informant Joseph E. Henry (Son)  
(Address) 948 Hallway St.

15 Filed Robert F. Harrison Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1<sup>st</sup> 1922

17 I HEREBY CERTIFY, That I attended deceased from  
Jan 20, 1922 to Feb 1st, 1922  
that I last saw him alive on Jan. 31, 1922.  
and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH\* was as follows:

William F. Dubois.

(duration) 2 yrs. — mon. — da

**CONTRIBUTORY**  
(Secondary)

(duration) ..... yrs. .... mos. .... d.

18 Where was disease contracted if not at place of death? 653 Th Rex, St

Did an operation precede death? no Date of 11-1-68

Was there an autopsy? ..

What test confirmed diagnosis?

(Signed) \_\_\_\_\_

19 (Address) 888 W. Lombard St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18. PLACE OF BURIAL, CREMATION OR REMOVAL		DATE OF BURIAL

St Peter's Cemetery 2/4/21

30 UNDER TAKER

By G. Frederick Fulton & Sturges

**CAUSE OF DEATH** in plain terms, so that it may be properly understood. See instructions on back of certificates.

B8-1922 Social Permit Clerk.

D 60942

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60942

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Prindley Rd Wallace* ST. *27* WARD)2-FULL NAME *Louis J. Young*

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. *Same* ST. .... WARD. ....

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos. *13*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*Wht*

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 20/22*

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*13*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto.*  
(State or country)10 NAME OF FATHER *Louis A. Young*11 BIRTHPLACE OF FATHER (city or town) *Balto. Co.*  
(State or country)12 MAIDEN NAME OF MOTHER *Mary Ella Pyle*13 BIRTHPLACE OF MOTHER (city or town) *Harford Co. Md.*  
(State or country)

14

Informant  
(Address)*Mr. Louis A. Young  
Prindley Rd.*

15

*Robert F. Harrison,*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 2<sup>nd</sup> 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*July 2<sup>nd</sup> 1922* to *July 2<sup>nd</sup> 1922*that I last saw *him* alive on *July 1<sup>st</sup> 1922*and that death occurred, on the date stated above, at *1 P.* m.

The CAUSE OF DEATH\* was as follows:

*Hepatic Jaundice  
12 days.*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
If not at place of death?*Long. report of gall  
bladder*

Did an operation precede death?

Date of

Was there an autopsy?

*no*

What test confirmed diagnosis?

*Visible*

(Signed)

M. D.

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Forest Hill Harford Co.**Feb 4 1922*

20 UNDERTAKER

ADDRESS *1203**Henry Lutz**N. Broadway*

83-1922

Serial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 60943

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60943

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1929 Walbrook Cor. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby McClelland(a) RESIDENCE. NO. 1929 Walbrook Cor. 15 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. — mos. — ds.

How long in U. S. if of foreign birth?

yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white5 Single, Married, Widowed,  
or Divorced (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 2-2-22

7 AGE

Years

Months

Days

If LESS than  
1 day, /1 hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)10 NAME OF FATHER James McClelland

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Eva Leonard

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15

Filed

Robert P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-3-1922

17

I HEREBY CERTIFY, That I attended deceased from

2-2-1922, to 2-3-1922,that I last saw him alive on 2-3-1922,and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH\* was as follows:

Premature birth  
(6 1/2 mos)

(duration) yrs. — mos. — ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. — mos. — ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

Address) 2202 W North\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Loudon Park Cem.Feb 4 1922

20 UNDERTAKER

ADDRESS

Harry W. ChlenW. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

83-1922

Burial Permit Clerk.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60944

D 60944

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1622 Mt Royal av. 1st

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Mary L. W. Ballard

(Residence in Baltimore: No.

1622 Mt. Royal av

St.; 20 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-STATUS,

MARRIED,

WIDOWED,

OR SEVERED,

(Write the word.)

Widow

6-DATE OF BIRTH,

August 7,

1841

(Month)

(Day)

(Year)

7-AGE,

80 yrs., 5 mos., 26 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Somerset Co. Md

10-NAME OF FATHER,

Henry J. Davy

11-BIRTHPLACE OF FATHER (State or Country),

—

12-MAIDEN NAME OF MOTHER

Mary E. Waters

13-BIRTHPLACE OF MOTHER (State or Country),

—

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Edwin K. Ballard

(Address)

1622 Mt Royal av

15-

EB 5-1922 Robert P. Harrison,

Registrar.

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

February 2, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 23 1922, to Feb 2 1922.

that I saw her alive on Feb 2 1922.

and that death occurred, on the date stated above, at 10<sup>45</sup> a.m.

The CAUSE OF DEATH\* was as follows:

Influenza

(Duration) yrs. mos. ds. 4 ds.

CONTRIBUTORY (Secondary)

Broncho-pneumonia

(Duration) yrs. mos. ds. 8 ds.

(Signed) Edwin K. Ballard, M. D.

Feb 3, 1922 (Address) 1622 Mt Royal

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Crownpoint Cem Feb 4, 1922

20-UNDERTAKER

ADDRESS

William Cook 522 E. North



D 60945

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60945

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4764 Pimlico Road ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mary F. Stewart(a) RESIDENCE. No. 4764 Pimlico Road ST. 27 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 5 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel C. Stewart6 DATE OF BIRTH (month, day, and year) Aug 13, 18767 AGE Years 45 Months 5 Days 19 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Jos. M. Leake11 BIRTHPLACE OF FATHER (city or town) MD (State or country)12 MAIDEN NAME OF MOTHER William Anna Stansbury13 BIRTHPLACE OF MOTHER (city or town) Carroll Co Md (State or country)14 Informant Samuel C. Stewart (Address) 4764 Pimlico Rd.15 Filed Robert P. Harrison Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 19 22

17

I HEREBY CERTIFY That I attended deceased from

Jan 3 19 21 to Feb 2 19 22 that I last saw him alive on Feb 2 19 22and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH\* was as follows:

Diabetes(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D. Butler M. D., 19 (Address) 4814 Park Heights Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Ormid Ridge Cem Feb 6 19 22

20 UNDERTAKER

Harry W. Ehlen ADDRESS 1944 W. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. State must be given. See instructions on back of certificates.

83

1922

Permit Clerk

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60946

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1042 N. Arlington Ave. WARD 16)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1042 N. Arlington Ave. St.: Life yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, single MARRIED, WIDOWED, OR DIVORCED, (Write the word.)6-DATE OF BIRTH, ? 1876 (Month) (Day) (Year)7-AGE, about 45 yrs. mos. ds. If LESS than 1 day, ....hrs. or....min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, Telegraph Operator (b) General nature of industry, business, or establishment in which employed (or employer), 0869-BIRTHPLACE, (State or Country), Balto. Md.10-NAME OF FATHER, John A. Smith11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.12-MAIDEN NAME OF MOTHER Catherine Anderson13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah L. Smith(Address) 1042 N. Arlington Ave.

15-

Robert P. Harrison, Registrar.

Filed 3-1922

Social Permit (None)

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 1st, 1922. (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Jan 19th 1922, to Feb 1st 1922, that I saw him alive on Feb 1st 1922, and that death occurred, on the date stated above, at 6 P. m. The CAUSE OF DEATH\* was as follows:Acute Bright Disease of the Kidneys (Duration) ....yrs. ....mos. ....ds.CONTRIBUTORY (Secondary) Unsanitary Housing, Eclampsia (Duration) ....yrs. ....mos. ....ds.(Signed) John A. Smith M. D. Feb. 3rd 1922 (Address) 1142 N. ...

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAVELERS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. DATE OF BURIAL, 2/4, 192220-UNDERTAKER William Cook ADDRESS 502 E. North Ave.

## Probably chronic nephritis.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

*lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

*Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.*

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.

D 60947

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60947

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1400 E. Preston* ST.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*Albert S. Shore*(Residence in Baltimore: No. *1400 E. Preston* St.; *78* yrs., *9* mos. *6* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE,

*White*5-STATUS,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)  
*Married*

## 6-DATE OF BIRTH

*3-6-1860*  
(Month) (Day) (Year)

## 7-AGE,

*71**9* mos. *6* ds.

IF LESS than 1 day.

*hrs. or min.*

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Gas Inspector*  
*186*9-BIRTHPLACE,  
(State or Country),*Baltimore*

## 10-NAME OF FATHER,

*Joseph Shore*

## 11-BIRTHPLACE OF FATHER

(State or Country),

*Balti Md*

## 12-MAIDEN NAME OF MOTHER

*Leah Rumm*

## 13-BIRTHPLACE OF MOTHER

(State or Country),

*Balti Md*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Albert S. Shore*

(Address)

*1400 E. Preston*

## 15-

Filed

*Robert P. Harrison*

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*2-2-1922*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *1/20* 19*22*, to *2/2* 19*22*, that I saw him alive on *2/2* 19*22*, and that death occurred, on the date stated above, at *4 P.* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Interstitial Nephritis**Alcohol* (Duration) *2* yrs. *—* mos. *—* ds.CONTRIBUTORY  
(Secondary)(Duration) *—* yrs. *—* mos. *—* ds.(Signed) *Dr. A. W. E. E. E.* M. D.*2/2* 19*22* (Address) *2017 North Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs. *—* mos. *—* ds. In the *—* yrs. *—* mos. *—* ds. State *—*

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Baltimore*

## DATE OF BURIAL,

*2/6* 19*22*

## 20-UNDERTAKER

*William Cook*

## ADDRESS

*502 E North Ave*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

-1922

Serial Permit 61812



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60948

D 60948

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2711 N. Lafayette ST., 16 WARD)

## 2-FULL NAME

Mary Francis Wantz

## (a) RESIDENCE NO.

2711 N. Lafayette Ave.

WARD

(If non-resident of city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred

3 yrs.

mos.

ds.

How long in U. S., if of foreign birth

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Noah S. Wantz

6 DATE OF BIRTH (month, day, and year)

unknown, 1843?

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

78

Feb?

-

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Albert Rubin

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Noah S. Wantz 2711 N. Lafayette Ave.

15

Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3rd 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 3rd, 1922, to Feb 3rd, 1922, that I last saw her alive on Feb 2nd, 1922

and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH\* was as follows:

Apoplexy

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

Bronchial Asthma

(duration) 8 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. S. Grant, M. D.

19 (Address) 1207 North Green

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Paul's Cathedral Feb 6 1922

ADDRESS

William Oak 5028 North

CAUSE OF DEATH in plain terms, so that it may be properly examined. See instructions on back of certificates.

3-1922

Burial Permit Blank

D 60949

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60949

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1903 Park Ave. ST. 14 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mary Severson

## (a) RESIDENCE NO.

1903 Park Ave.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds.

How long in U. S., if of foreign birth? 1 yr. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX : 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1853

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 68 - -

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md

10 NAME OF FATHER Stephen W. Severson

11 BIRTHPLACE OF FATHER (city or town) Cecil Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Emich

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant Naomi E. Severson (Address) 1913 Linden Ave.

15

Robert P. HARRISON,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2<sup>nd</sup> 19 22

17

I HEREBY CERTIFY, That I attended deceased from Jan 20<sup>th</sup>, 19 22, to Feb 2<sup>nd</sup>, 19 22, that I last saw her alive on Feb 1<sup>st</sup>, 19 22, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH\* was as follows:

Angina Pectoris

(duration) - yrs. - mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) 4 yrs. - mos. - ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical only

(Signed) Eugene Douglas, M. D.

Feb. 2<sup>nd</sup>, 19 22 Address 830 W. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Green Mount

Feb 4 1922

20 UNDERTAKER

ADDRESS

202 B Cook

1103 N. Balaban

maison should be carefully supervised. Exact statement of occupation should be given. Cause of death in plain terms, so that it may be properly classified. See instructions on back of certificates.

83-1922

Serial Permit Clerk.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60950

## CERTIFICATE OF DEATH.

90D 60950

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 128 E. Ostend

ST. 24 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. 128 E. Ostend

ST. 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 9 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 17, 1900

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

16

8

15

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Shirts Factory

(b) General nature of industry, business, or establishment in which employed (or employer)

Mfg. Shirts

(c) Name of employer

Erlanger Bros.

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Ernest E. Schroeder

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md. Balt.

12 MAIDEN NAME OF MOTHER

Billie Kelley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md. Balt.

14

Informant (Address)

Ernest E. Schroeder 128 E. Ostend St.

15

Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 1 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 29, 1922, to Apr 1, 1922,

that I last saw him alive on Apr 1, 1922,

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH\* was as follows:

Mitral Insufficiency

CONTRIBUTORY (Secondary) duration yrs. mos. ds. 4

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? M. D.

(Signed) R. A. Campbell

1922 (Address) 1644 Hanson

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

3-1922

Burial Permit Clerk.

D 60951

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60951

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

University Hospital

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mary R. Meyer

## (a) RESIDENCE

No. 106 W. Hamilton Ave.

WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. 8 mos. 2 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female white Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Married - John F. Meyer Jr.

6 DATE OF BIRTH (month, day, and year)

May 30, 1893

7 AGE

Years

Months

Days

If LESS than 1 day hrs. or min.

29

8

2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore City

10 NAME OF FATHER

William H. O'Brien

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore City

12 MAIDEN NAME OF MOTHER

Emily Airey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore City

14

Informant (Address)

John F. Meyer Jr.  
106 W. Hamilton Ave.

15

Filed

Robert P. Harrison

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 2, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 27, 1922, to Feb. 2, 1922

that I last saw her alive on Feb. 2, 1922

and that death occurred, on the date stated above, at 4:22 PM.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Cellulitis of face

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of Jan. 27, 1922

Was there an autopsy?

What test confirmed diagnosis? Examination

(Signed)

17, 1922 (Address)

J. B. Jones  
M. D.  
University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Parkwood Cemetery

2/4/22

20 UNDERTAKER

ADDRESS

George J. Puth 1735 Hayford

EB 4-1922

mation should be carefully supplied. XERO amount of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Operation for cellulitis  
cause of which is  
unknown.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60952

D 60952

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

Baltimore City

CITY OF BALTIMORE: No.

1717 N. Caroline

ST.:

8

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William Lewis Link Jr

(a) RESIDENCE, No.

1717 N. Caroline

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

1

mos.

15

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

—

6 DATE OF BIRTH (month, day, and year)

Dec. 19-1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore City

10 NAME OF FATHER

William Lewis Link

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore City

12 MAIDEN NAME OF MOTHER

Ellen P. Krating

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pennsylvania

14

Informant (Address)

L. Link M.D.  
1717 N. Caroline St.

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

January 30, 1922, to Feb 3, 1922, that I last saw him alive on Feb 2, 1922,

and that death occurred, on the date stated above, at 9. A. M.

The CAUSE OF DEATH\* was as follows:

Diptheria (nasopharyngeal)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 6 ds.

Broncho-pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? - Physian sign no 1 member

(Signed) J. H. Harrison, M. D.

, 19 (Address) 24 39 N. Charles

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

2/4/22 19

20 UNDERTAKER

ADDRESS

George F. Smith

1735 N. Hanford Ave

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

34-1922

D 60953

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60953

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 915 Ramsey

ST.: 21

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Annie Elizabeth Murray

## (a) RESIDENCE. NO.

915 Ramsey

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 5 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

female

## 4 COLOR OR RACE

white

## 5 Single, Married, Widowed, or Divorced (write the word)

widow

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

William F Murray

## 6 DATE OF BIRTH (month, day, and year)

Aug 21<sup>st</sup> 1864

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

57

5

12

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

House work

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

## 10 NAME OF FATHER

John J Coatsley

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

## 14

## Informant (Address)

Mrs. Thos Murray 915 Ramsey St.

## 15

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

2-2-1922

## 17 I HEREBY CERTIFY, That I attended deceased from

home 7:20. to 2-2-22, 1922

that I last saw her alive on (date) 2-2-1922

and that death occurred, on the date stated above, at 4 A. M.

## The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

## Did an operation precede death?

Was there an autopsy?

## What test confirmed diagnosis?

(Signed) John G. Seligman, M. D.

, 19 (Address) 1120 W Cross St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

New Cathedral Cem.

Feb 6<sup>th</sup> 1922

## 20 UNDERTAKER

## ADDRESS

John G. Cowan &amp; Son 901 Hall's St

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

84-1922

D 60954

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 60954

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Einakis(a) RESIDENCE. No. 30 Albemarle st. ST. 7 WARD. Unknown

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 years mos. ds. How long in U. S., if of foreign birth Unknown mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Eliza Einakis6 DATE OF BIRTH (month, day, and year) 1886 ?7 AGE Years 36 ? Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia10 NAME OF FATHER Joseph Einakis11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia12 MAIDEN NAME OF MOTHER Karlmin Peterson13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia14 Informant Hospital Records (Address) M.T.H.15 Robert P. Harrison Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2, 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1922 to Feb. 2, 1922that I last saw him alive on Feb. 2, 1922and that death occurred, on the date stated above, at 9.35 p. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(duration) yrs. 4 mos. ds.CONTRIBUTORY Chronic nephritis (Secondary)(duration) Unknown mos. ds.18 Where was disease contracted If not at place of death? UnknownDid an operation precede death? NO Date ofWas there an autopsy? YESWhat test confirmed diagnosis? T.B. in sputum, X-ray(Signed) Francis J. Padayachee M. D.2-3-22 (Address) Municipal Tbc. Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy RedeemerFeb 6th 1922

20 UNDERTAKER

ADDRESS

John Grebliauckas425 S Paca

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

4-1922



D 60955

Spec.—6-9-19—H. P. Co.—1000 Pla.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 60955

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2303 Harford Ave ST.: 8 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. P. Luskin(a) RESIDENCE. No. 2303 Harford ST. WARD. (If nonresident give city or town and State)  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed or divorced HUSBAND of Emily L. Luskin6 DATE OF BIRTH (month, day, and year) 2-12-18807 AGE Years Months Days If LESS than 1 day, hrs. or min.  
41 11 20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Toal maker 31

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self Employed9 BIRTHPLACE (city or town) Balti md  
(State or country)10 NAME OF FATHER John Luskin11 BIRTHPLACE OF FATHER (city or town) Balti md  
(State or country)12 MAIDEN NAME OF MOTHER Carrie Geist13 BIRTHPLACE OF MOTHER (city or town) Balti md  
(State or country)14 Informant Harry Biles  
(Address) 2226 Harford Ave15 Robert P. Harrison

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-2 192217 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1922, to Feb 2, 1922, that I last saw him alive on Feb 2, 1922, and that death occurred, on the date stated above, at 4:35 P. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia(duration) yrs. mos. ds. 8

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physioid(Signed) A. L. Hornstein, M. D.7/3, 1922 (Address) 733 Argus St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Landon Park Land Feb 6 1922

20 UNDERTAKER

ADDRESS

Ch. Hermann 995 Broad

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 60956

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60956

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1451 Woodall*)ST.: *24* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mary E. Allen*(a) RESIDENCE. No. *1451 Woodall*  
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *28* yrs. *11* mos. *26* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced (write the word)*Female white married*6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*John Allen*6 DATE OF BIRTH (month, day, and year) *2-8-1893*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*28 11 26*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Housewife*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore Md*

10 NAME OF FATHER

*John T. Cooper*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Md*

12 MAIDEN NAME OF MOTHER

*Matilda Weber*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Baltimore Md*

14

Informant  
(Address)*John Allen  
1451 Woodall St*

15

Filed

*Robert P. Harrison*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2-3-1922*

17

I HEREBY CERTIFY, That I attended deceased from

*January 31-1922 to February 3-1922*that I last saw her alive on *February 3-1922*and that death occurred, on the date stated above, at *7-A* m.

The CAUSE OF DEATH\* was as follows:

*Puerperal Infection*(duration) yrs. mos. *5* ds.CONTRIBUTORY  
(Secondary)*Toxemia*

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date of *✓*Was there an autopsy? *no*What test confirmed diagnosis? *Physical examination*(Signed) *E. B. Burton*, M. D.*2/4, 1922* Address *301 East Cross St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Oak Lawn Cem**2-6 1922*

20 UNDERTAKER

ADDRESS

*Ernest Harle**115 E. 2nd St*

TION is very important. See instructions on back of certificates.

D 60957 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. Veterans' Hosp. #56

REGISTERED NO.

CITY OF BALTIMORE: (No. Ft. McHenry, Baltimore, Md. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Spence, John

(a) RESIDENCE No. Ft. McHenry, Md..

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos.

ds. How long in U. S., if of foreign birth?

yrs. mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

---

6 DATE OF BIRTH (month, day, and year)

----

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

58

--

-

-

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lighthouse keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

--

(c) Name of employer

--

9 BIRTHPLACE (city or town)  
(State or country)

Va.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Unknown

14

Informant  
(Address)E.T. Rosenbrock Registrar  
USV Hosp. #56,

4-1922

Robert L. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/3/22 19

17

I HEREBY CERTIFY, That I attended deceased from  
Jan. 14, 1922 to Feb. 3, 1922

that I last saw him alive on Feb. 3, 1922

and that death occurred, on the date stated above, at 12.30 A.m.

The CAUSE OF DEATH\* was as follows:

Diabetic Mellitus

(duration) Unknown yrs. mos. da.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted  
if not at place of death?

Unknown

Did an operation precede death? No Date of

Was there an autopsy?

No

What test confirmed diagnosis? Clinical

(Signed)

F. N. Gordon Surgeon (R) USPHS M. D.

1/4, 1922 (Address) USV Hosp. #56, Balto. Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Trinity Cemetery 2/4/22, 22  
J. Quinn Bros E. Balto. Md.

D 60958 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60958

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.; 6 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Harris(a) RESIDENCE. No. 1605 Orleans St

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>Black</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Married</u>
----------------------	---------------------------------	---

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
<u>40</u>	<u>--</u>	<u>--</u>	<u>--</u>	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work Laborer(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) Virginia10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Unknown14 Informant Hospital Records,  
(Address) Municipal Hospital.15 Robert P. Harrison,  
Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2 19 2217 I HEREBY CERTIFY, That I attended deceased from  
December 6, 19 21, to February 2, 19 22.that I last saw him alive on February 2, 19 22.and that death occurred, on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH\* was as follows:

Myocardial Infarction(duration) 1 yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? YesWhat test confirmed diagnosis?  
(Signed) Clifford M. Murrell M. D.2/2/1922 Address Municipal Hospital.\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Auburn Cemetery Feb 5 1922

20 UNDERTAKER

ADDRESS

Milton Davis 315 N. E. Ave

1X

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

84-1922



D 60959

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60959

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal HospitalST.: 2 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie Ross(a) RESIDENCE. NO. 213 S. Durham St.ST. 2 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1949

7 AGE

72

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant Hospital Records, (Address) Municipal Hospital.

15

Filed Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1 1922

17

I HEREBY CERTIFY, That I attended deceased from October 7, 1919, to February 1, 1922

that I last saw her alive on February 1, 1922

and that death occurred, on the date stated above, at 10:25 P.M.

The CAUSE OF DEATH\* was as follows:

Broncho pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

2/2/1922 Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Auburn Cemetery Feb 22

20 UNDERTAKER

ADDRESS

Mittas Davis 316 N E-G

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

FEB 4 - 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60960

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Square Hospital* ST. *16* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Maurice L. Treffinger*(Residence in Baltimore: No. *1101 N. Stucker St* St. *8* yrs. *8* mos. *22* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>Female</i>	4-COLOR OR RACE, <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <i>Married</i>
6-DATE OF BIRTH, <i>May 11, 1894</i> (Month) (Day) (Year)		
7-AGE, <i>27</i> yrs. <i>8</i> mos. <i>22</i> ds. IF LESS than 1 day, ...hrs. or...min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). <i>Sanitress 169</i>		

9-BIRTHPLACE,  
(State or Country)

## 10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

## 12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Maurice Shores*(Address) *1101 N. Stucker St*

## 15-

Filed *Robert P. Harrison*

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb 2, 1922*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Jan 26* 19*22*, to *Feb 2* 19*22*, that I saw her alive on *Feb 2* 19*22*, and that death occurred, on the date stated above, at *11-15* m.

The CAUSE OF DEATH was as follows:

*Sci. lateral, Pulmonary, Colitis*  
*chronic*

(Duration) *4* yrs. *1* mos. *12* ds.

## CONTRIBUTORY (Secondary)

*Aspiration* (Duration) *1* yrs. *1* mos. *12* ds.(Signed) *Ed. H. Harrison*

M. D.

*Feb 2, 1922* (Address) *1922, Edmondson Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *5* yrs. *5* mos. *5* ds. In the State *5* yrs. *5* mos. *5* ds.Where was disease contracted, if not at place of death? *at home*Former or usual residence *1101 N. Stucker St*

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL

## 20-UNDERTAKER

## ADDRESS

*J. Michaels*  
*Joseph B. Cook* *1063 N. Baltimore*

B4-1922

Burial Permit Clerk.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60961

D 60961

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2128 Brookfield Ave.* ST. *13* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OF RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Aug 27 1858*

7 AGE

*63*

Years

*6*

Months

*6*

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Indus Broker*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balt Md*

10 NAME OF FATHER

*Max Stein*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Golda Walter*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*

14

Informant (Address)

*Mrs J Becht 2121 Brookfield Ave*

15

Filed

1922

Robert P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*July 8 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*October 1, 1921, to Feb 3, 1922*that I last saw him alive on *Feb 3, 1922*

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

*Cancer of upper jaw (carcinoma)*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Exhaustion, prostration*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

*no*

What test confirmed diagnosis?

*Observation*(Signed) *Joseph J. Schickel*, M. D.19 (Address) *1516 Madison Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Club Shelton**July 8 1922*

20 UNDERTAKER

ADDRESS

*David Sandberg**1124 W 4th St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

Burial Permit 62222

D 60962 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No.

1908 Madison Ave

ST.

WARD)

## 2-FULL NAME

Emanuel M. Eilan

(Residence in Baltimore: No.

1908 Madison Ave

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 47 yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)

6-DATE OF BIRTH,

July 16<sup>th</sup>, 1854 (Month) (Day) (Year)

7-AGE,

67 yrs. 11 mos. 17 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

Physician

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Mr. Eilan

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Indum

13-BIRTHPLACE OF MOTHER (State or Country),

Michigan

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Kate Eilan

(Address)

1908 Madison Ave

15-

Robert P. Harrison,

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 2<sup>nd</sup>, 1922 (Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, and that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Angina pectoris

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Harrison, M. D.

(Coroner.)

Feb. 3, 1922 (Address) 2802 Edmonson

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

L. J. Anderson

1824 W. Bay St.

Every item of information should be carefully supplied. For reasons very important. See instructions on back of certificate.

FEB 4 - 1922

101

Burial Permit



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60963

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1809 N. Register ST., 8 WARD)

## 2. FULL NAME

(a) RESIDENCE NO. 1809 N. Register ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 6 ds. How long in U. S., if of foreign birth? 18 mos. 6 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single Married, Widowed, or Divorced. Write the word Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27 1920

7 AGE Years 1 Months 6 Days 6 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Louis Schrufer

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Bertha Schrufer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant M. Louis Schrufer (Address) 1809 N. Register

15 Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 3<sup>rd</sup> 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 30, 1922, to Feb 3, 1922, that I last saw him alive on Feb 3, 1922, and that death occurred, on the date stated above, at 4<sup>45</sup> P. m.

The CAUSE OF DEATH\* was as follows:

Tubercular pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. P. Waggoner, M. D.

(Address) 1206 E. Preston

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Baltimore Cemetery Feb 6, 1922

20 UNDERTAKER

ADDRESS

Henry Horckow 1301 E. Bay

Exact statement of OCCUPATION should be carefully supplied. Cause of DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

84-1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60964

D 60964

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1729 Aiken* ST., *9* WARD)2. FULL NAME *Mary Sechner*(a) RESIDENCE NO. *1729 Aiken* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred *5* yrs. *2* mos. *—* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*5a If married, widowed, or divorced HUSBAND of *John Aiken Sechner* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *Nov 1888*7 AGE Years *78* Months *—* Days *—* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Austria* (State or country)10 NAME OF FATHER *Frank Mosmiller*11 BIRTHPLACE OF FATHER (city or town) *Austria* (State or country)12 MAIDEN NAME OF MOTHER *Anna Mosmiller*13 BIRTHPLACE OF MOTHER (city or town) *Austria* (State or country)14 Informant *Mrs Henry Berk* (Address) *1729 Aiken*15 *Robert P. Harrison* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 3* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *Dec 15* 19 *21* to *Feb 3* 19 *22* that I last saw her alive on *Feb 1* 19 *22* and that death occurred, on the date stated above, at *1 P.* m.

The CAUSE OF DEATH\* was as follows:

*Parasit & Senility* (duration) *Indefinite* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *A. Schatz* M. D.19 (Address) *1107 N. Caroline St.*

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

*Holy Resurrection Cemetery* *Feb 6* 19 *22*

20 UNDERTAKER

*Henry Wood Sen*

ADDRESS

*1301 E Eager St*

Exact statement of LOCAL CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

1107 A

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATH state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Not listed in origin*  
*General paralysis*

D 60965 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60965

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital

ST.: 76 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Fisher

(a) RESIDENCE NO. Unknown  
(Usual place of abode)

ST. WARD.

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? *Life* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 67 -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,  
(State or country) Maryland

10 NAME OF FATHER Godfrey Fisher

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Koehel

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Germany14 Informant Hospital Records,  
(Address) Municipal Hospital.

15 Robert P. Harrison, Registrar

Burial Permit No.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 1<sup>st</sup> 22

17 I HEREBY CERTIFY, That I attended deceased from January 31, 1922, to February 1, 1922, that I last saw him alive on February 1, 1922, and that death occurred, on the date stated above, at 2:15 P.M.

The CAUSE OF DEATH\* was as follows:

Chronic myocarditis  
Chronic emphysemaCONTRIBUTORY  
(Secondary)18 Where was disease contracted  
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

2/3/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Trinity Cemetery Feb 6 1922

20 UNDERTAKER ADDRESS

Mrs C. Miller 1334

Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FR4-1022



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL, ST.: 9 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

## (a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

male

## 4 COLOR OR RACE

white

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant (Address)

## 15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan. 5<sup>th</sup>, 1922, to Feb. 3<sup>rd</sup>, 1922that I last saw him alive on Feb. 3<sup>rd</sup>, 1922

and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH\* was as follows:

Meningitis, purulent (not meningococcus)

(duration) yrs. 1 mos. 24 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. 24 ds.

## 18 Where was disease contracted

If not at place of death? 1911 Sherwood Ave.

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Spinal &amp; Venous fluid and Gram stain &amp; culture for meningitis (Signed) J. B. Goss, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

84-1922

Burial Permit Clerk

D 60967

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1411 Bruce ST. 16 WARD)2-FULL NAME Richard Henry Waters(a) RESIDENCE. No. 1411 Bruce ST. 16 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widowed6a If married, widowed, or divorced HUSBAND of Waters (or) WIFE of6 DATE OF BIRTH (month, day, and year) 18657 AGE Years 56 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Colonel(b) General nature of industry, business, or establishment in which employed (or employer) Hod Carrier(c) Name of employer Balwin Co. Inc.9 BIRTHPLACE (city or town) Baltimore Co. Md. (State or country)10 NAME OF FATHER Samuel Waters11 BIRTHPLACE OF FATHER (city or town) Baltimore Co. (State or country)12 MAIDEN NAME OF MOTHER Eloza Spriggs13 BIRTHPLACE OF MOTHER (city or town) Colombia Co. (State or country)14 Informant Malbur Waters (Address) 1356 Whitcomb15 Filed PER 4-19-22 J. E. Hahn Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 19 2217 I HEREBY CERTIFY, That I attended deceased from Jan 22, 19 22, to Feb 2, 19 22, that I last saw him alive on Feb 1, 19 22,and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH\* was as follows:

Interstitial Nephritis.(duration) yrs. 4 mos. ds.CONTRIBUTORY Arteriosclerosis & Epistaxis (Secondary) (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Urinary etc. (Signed) Wm H Wright M. D.(Address) 1209 Princeton St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Luke's DATE OF BURIAL Feb 2 19 2220 UNDERTAKER Wm H Wright ADDRESS 1209 Princeton St

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 60968

HEALTH DEPARTMENT - CITY OF BALTIMORE

D 60968

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *5320 Decumore* ST. *27* WARD)2-FULL NAME *Mildred Florence Wiggington*(a) RESIDENCE NO. *5320 Decumore* ST. *27* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *2* yrs. *5* mos. *19* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 17 - 1913*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. *2* yrs. *5* mos. *19* ds.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Child out*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *md*10 NAME OF FATHER *Howard Wiggington*11 BIRTHPLACE OF FATHER (city or town) (State or country) *md*12 MAIDEN NAME OF MOTHER *Minnie E. Cammels*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *md*

14

Informant (Address) *Howard Wiggington*  
*5320 Decumore St.*

15

FEB 4 1922

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 2* 1922

17

I HEREBY CERTIFY, That I attended deceased from *Feb 1* 1922 to *Feb 2* 1922that I last saw *alive* on *Feb 2* 1922and that death occurred, on the date stated above, at *10:40* P. M.

The CAUSE OF DEATH\* was as follows:

*Measles.*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted (If not at place of death?) *Home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Culture*

(Signed)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Green Ridge Feb 6 1922*  
*Wendell Cook 20 E North*

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

D 60969 HEALTH DEPARTMENT—CITY OF BALTIMORE D 60969

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal HospitalST. 3

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Washington Beavers(a) RESIDENCE. NO. 311 S. Dallas St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 Single, Married, Widowed,  
or Divorced (write the word)  
Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Lucy Beavers

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

77

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## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Laborer

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Raleigh,  
(State or country) North Carolina10 NAME OF FATHER Washington Beavers11 BIRTHPLACE OF FATHER (city or town) Raleigh  
(State or country) North Carolina12 MAIDEN NAME OF MOTHER Tempie Lane13 BIRTHPLACE OF MOTHER (city or town) Raleigh  
(State or country) North Carolina14 Informant Hospital Records,  
(Address) Municipal Hospital.15 Robert P. Harrison,

Registrar

## 20 UNDERTAKER

Commissioner Health,

## DATE OF BURIAL

19

## ADDRESS

FEB 4 - 1922

16 DATE OF DEATH (month, day, and year) Jan. 31 19 22

17

I HEREBY CERTIFY, That I attended deceased from  
January 12, 1922, to January 31, 1922.that I last saw him alive on January 31, 1922.and that death occurred, on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. M. Neill

M. D.

2/1/22 (Address) Municipal Hospital.\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## 20 UNDERTAKER

Commissioner Health,

## ADDRESS

FEB 4 - 1922

mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

84 - 1922

Robert P. Harrison,

Registrar

18871  
Permit Clerk



D 60970 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60970

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 S. Second

ST. 76 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick B. Schroeder

(a) RESIDENCE. No. 1017 S. Second  
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 3 mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of  
WIFE of

Katharine Schroeder

6 DATE OF BIRTH (month, day, and year) Nov. 2-1876

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

45

3

1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Laborer

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer Southern Can Co.

9 BIRTHPLACE (city or town)  
(State or country) Baltimore, Md.

10 NAME OF FATHER Christian Schroeder

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany.

12 MAIDEN NAME OF MOTHER Marie Schmetzer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany.

14 Informant Katharine Schroeder

(Address) 1017 S. Second St.

15

Filed Robert P. Harrington Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

12/30/21, 19, to 2/3, 1922

that I last saw him alive on 2/3/22, 19

and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic industrial Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

Orders of lung 3 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. B. Gannett M. D.

3/4, 1922 Address 633 S. 3rd St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Matthews Cem.

DATE OF BURIAL

Feb 6 1922

20 UNDERTAKER

Zirkler + Zirkler

ADDRESS

1739 E. Eager St.

Information should be carefully supplied. Note amount of money around CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

B4-1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60971

D 60971

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *11 N Ann St*)ST., *6* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Bessie Schiff*(a) RESIDENCE NO. *11 N Ann St*

ST., \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *16* yrs. mos. ds.How long in U. S., if of foreign birth? *16* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White Widowed*

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

*Jacob Schiff*

6 DATE OF BIRTH (month, day, and year)

*March 1850*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*71 — —*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Russia*

10 NAME OF FATHER

*Isidor*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Russia*

12 MAIDEN NAME OF MOTHER

*Isidor*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Russia*

14

Informant (Address)

*Henry E. Ewald*

15

Filed

*Robert P. Harrison*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 9* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan* 19*21* to *Feb 9* 19*22*that I last saw him alive on *Feb 10* 19*22*and that death occurred, on the date stated above, at *104* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Endocarditis**Chronic Interstitial Nephritis**Chronic Bronchitis*(duration) *Long* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of \_\_\_\_\_Was there an autopsy? *No*What test confirmed diagnosis? *Chemical Exam.*(Signed) *A. F. Ries* M. D.*Feb 4* 19*22* (Address) *24 S. Broadway*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Myer Rossdals**2-5* 19*22*

20 UNDERTAKER

ADDRESS

*Jack Lewis, 1437 E. Baltimore*

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS SHOULD FURNISH CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

84-1922

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60972

D 60972

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Pennsylvania Ave, near La Fayette* ST. *La Fayette* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Henry Garrison*

(Residence in Baltimore: No. *1519 Shields alley*)

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*male*

4-COLOR OR RACE,

*col.*

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

*married*

6-DATE OF BIRTH,

*November, 1869*

7-AGE,

*53*

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

*Laborer*

9-BIRTHPLACE,

(State or Country),

*Baltimore, Md*

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mabel Garrison*

(Address) *1519 Shields alley*

15-

ROBERT R. KRAUTER,

Filed FEB 5 - 1902 191. Burial Permit *CL*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Feb. 2, 1902*

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) and that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Cerebral hemorrhage*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *no history*

(Duration) yrs. mos. ds.

(Signed) *J. T. Garrison* M. D.

(Coroner.)

*Feb. 4, 1902* (Address) *2802 Eastman*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

*Laurel Cem*

*Feb 6 1902*

20-UNDERTAKER

ADDRESS

*Daniel Easton*

*Rd on*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60973

## CERTIFICATE OF DEATH.

178 D 60973

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Provident Hospital* ST. *11* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Amanda Brown*

## (a) RESIDENCE. NO.

*1215 Park Ave* ST.

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *20* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*Col*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Thos. Q. Brown*

## 6 DATE OF BIRTH (month, day, and year)

*Unknown*

## 7 AGE

*64*

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Domestic*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Housework*

(c) Name of employer

*Self*

## 9 BIRTHPLACE (city or town). (State or country)

*N.Y.*

## 10 NAME OF FATHER

*Not given*

## 11 BIRTHPLACE OF FATHER (city or town). (State or country)

*Not given*

## 12 MAIDEN NAME OF MOTHER

*Not given*

## 13 BIRTHPLACE OF MOTHER (city or town). (State or country)

*Not given*

## 14

Informant (Address)

*Ezra J. Taylor 928 N. Howard*

## 15

File

*FEB 5 - 1922*

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*Feb 1 1922*

## 17

HEREBY CERTIFY, that I attended deceased from

*Jan 8, 1922, to Feb 1, 1922.*that I last saw her alive on *Feb 1, 1922.*and that death occurred, on the date stated above, at *3:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*No Pericarditis, nephritis*

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Cannot say*Did an operation precede death? *No* Date of *-*Was there an autopsy? *No*What test confirmed diagnosis? *Urinary*(Signed) *E. S. Short* M. D.B. 19 (Address) *802 Duval Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

*mt Auburn Cem*

## DATE OF BURIAL

*Feb 7 1922*

## 20 UNDERTAKER

*Amos Carter*

## ADDRESS

*Beau*

Information should be carefully supplied. AGE should be stated EXACTLY. First name should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Not tuberculous. Acute  
nephritis due to  
exposure.*

D 60974

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

91-00 D 60974

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1505 E. Fager

ST.:

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Hess

(a) RESIDENCE. NO. 1505 E. Fager St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Divorced

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of August C. Hess

6 DATE OF BIRTH (month, day, and year) Dec. 10, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
72		1	21	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Unknown

14 Informant Charles Hess

(Address) 1505 E. Fager St.

15 FEB 5 - 1922 ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3rd 1922

17 I HEREBY CERTIFY, that I attended deceased from Jan 28th 1922, to Feb 2nd 1922,

that I last saw her alive on Feb 2nd 1922,

and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH\* was as follows:

Arthur Schreiner,  
Caused by difficulty  
(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Blomer, M.D.

, 19 (Address) 1501 E. Fager St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Green Mount Cem. Feb 6 1922

20 UNDERTAKER

ADDRESS

Wm. C. Black

927 N. Broadway

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60975

## CERTIFICATE OF DEATH.

D 60975

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 4 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Applegarth(a) RESIDENCE. NO. 214 St. Paul St ST. 4 WARD. 4  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18487 AGE Years 73 Months -- Days -- If LESS than 1 day, hrs. -- or min. --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Storekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,  
(State or country) Maryland10 NAME OF FATHER Nathaniel Applegarth11 BIRTHPLACE OF FATHER (city or town) Dorchester  
(State or country) Maryland12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Dorchester  
(State or country) Maryland14 Informant Hospital Records,  
(Address) Municipal Hospital.15 Filed 19 ROBERT R. KRAUTER,  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1 19 2217 I HEREBY CERTIFY, That I attended deceased from January 18, 19 22, to February 1, 19 22, that I last saw him alive on February 1, 19 22, and that death occurred, on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH\* was as follows:

uraemia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Feb

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

2/2/22 Address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60976

## CERTIFICATE OF DEATH.

D 60976

## 1-PLACE OF DEATH

CITY OF BALTIMORE: *Admiralty Hospital* ST. *28* WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Allan Ramsey Blacklock*(a) RESIDENCE. NO. *4900 Denmark Ave.* ST. *8* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *76* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb 28 1846*7 AGE *76* Years Months *11* Days *5* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.* (State or country)10 NAME OF FATHER *A.F. Blacklock*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Virginia*12 MAIDEN NAME OF MOTHER *S.E. Rushmore*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Maryland*14 Informant *A.H. Blacklock*(Address) *Beachwood Dr*15 *FEB 5 - 1922* ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 3, 1922*17 I HEREBY CERTIFY, That I attended deceased from *Feb. 2, 1922*, to *Feb. 3, 1922*, that I last saw him alive on *Feb. 3, 1922*, and that death occurred, on the date stated above, at *3:25 p.m.*

The CAUSE OF DEATH\* was as follows:

*Cardiac insufficiency acute suppression of urine - uremia*

(duration) yrs. mos. da.

CONTRIBUTORY *Hypertrophied prostate* (Secondary)*Acute Retention* (duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *Yes* Date of *Feb. 2, 1922*Was there an autopsy? *No*What test confirmed diagnosis? *Examination*(Signed) *J.W. Brown* M. D.2/3, 1922 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Greenmount* DATE OF BURIAL *Feb 6 1922*

20 UNDERTAKER

*Geo H Little* ADDRESS *2700 Edmondson*

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assoc.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Bladder*  
*Operation simply incision*  
*to relieve suppurative focus*  
*No chronic nephritis*  
*Man only in hospital one*  
*night.*

D 60977

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D 60977

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *19 Maryland General Hospital* WARD)

## 2-FULL NAME

*Martha M. Lauman*

## (a) RESIDENCE. NO.

*211 South Mount ST.*

## WARD.

(If nonresident give city or town and State)

(Usual place of abode)  
Length of residence in city or town where death occurred *52* yrs. *6* mos. *9* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Widowed*

## 5a If married, widowed, or divorced

(or) WIFE of

*Daniel W. Lauman*

## 6 DATE OF BIRTH (month, day, and year)

*July 23, 1869*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*52-**6**9*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Baltimore**Maryland*

## 10 NAME OF FATHER

*Robert Baker*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Maryland*

## 12 MAIDEN NAME OF MOTHER

*May C. Tupper*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Maryland*

## 14

Informant (Address)

*Old General Hospital*

## 15

*FEB 25 - 1922*

ROBERT K. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 4, 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan 4, 1922*, to *Feb 4, 1922*, that I last saw her alive on *Feb. 4, 1922*, and that death occurred, on the date stated above, at *3.20 A. M.*

The CAUSE OF DEATH\* was as follows:

*Incarcerated Umbilical Hernia*CONTRIBUTORY (duration) *14* yrs. mos. ds. *Cerebral Embolism and Phlebitis* (duration) yrs. mos. ds. *5*18 Where was disease contracted if not at place of death? *211 South Mount St.*Did an operation precede death? *Yes* Date of *Jan 6, 1922*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *John W. Hately*, M. D., 19 (Address) *Md. General Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*London Park*

DATE OF BURIAL

*Feb 7, 1922*

20 UNDERTAKER

*Easton Sons*

ADDRESS

*2800 E. City*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

60979

## CERTIFICATE OF DEATH.

60979

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

620 N. Dallas St.

ST.

WARD) 7

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Louisa Gayler

## (a) RESIDENCE NO.

620 N. Dallas

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female Colored Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Wife

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

43

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

House work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Born in Balt-

10 NAME OF FATHER

John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Elizav McGlock

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Cambridge

14

Informant

(Address)

Mrs R. A. Elliott  
1725- Ashland Ave

15

FEB 5 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 2, 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1921, to February 1, 1922 that I last saw her alive on Feb. 2, 1922 and that death occurred, on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH\* was as follows:

apoplexy  
asthma + dropsy  
complication of disease

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

asthma + dropsy

(duration) yrs. 2 mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. G. W. H. M. D.

Feb 3 1922 Address 708 Enoch St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL  
Inf Giron Cem

Feb 5 - 1922

20 UNDER TAKER

Mrs Robert A. Elliott

ADDRESS 1725-

Ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS AN IMPORTANT DOCUMENT. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be in plain terms, so that it may be properly classified. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 60980

## CERTIFICATE OF DEATH.

90

D 60980

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1233 E. Madison ST.: 10 WARD)

## 2-FULL NAME

Isaac Fields

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE. NO.

1233 E. Madison ST.,

## WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 2 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

C

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Unknown

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

70

✓

✓

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Ill

## 10 NAME OF FATHER

Forrace Fields

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ill

## 12 MAIDEN NAME OF MOTHER

Mollie unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ill

## 14

Informant (Address)

Hattie Fields

1233 E. Madison St.

ROBERT R. KRAUTER,

## 15

FEB 5 - 1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1922, to Feb 3, 1922,

that I last saw him alive on Feb 2, 1922,

and that death occurred, on the date stated above, at 11 am.

The CAUSE OF DEATH\* was as follows:

Aortic Insufficiency

(duration) 1 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Edward Fisher, M. D.

, 19 (Address) 1612 E. Monument St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

National

## DATE OF BURIAL

Feb 6 1922

## 20 UNDERTAKER

John W. Henderson

## ADDRESS

1502

Crown

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60981

## CERTIFICATE OF DEATH.

31 D 60981

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 N. Edew

ST.: 5 WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Robinson

(a) RESIDENCE. NO. 405 N. Edew

ST. WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE C 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

DECEASED or (or) WIFE of William Robinson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 42 Years Months Days If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

House Work

(c) Name of employer

9 BIRTHPLACE (city or town) Gloucester Co Va. (State or country)

10 NAME OF FATHER George Ward

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant William Robinson (Address) 405 N Edmest

15 ROBERT K. KRAUTER,

FEB 5 - 1922

Burial Permit Clerk.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1st 1922

17 I HEREBY CERTIFY, That I attended deceased from 11/14, 1921, to Feb. 1st, 1922.

that I last saw her alive on Feb. 1st, 1922.

and that death occurred, on the date stated above, at 2:00 P. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary T.B.C.

(duration) yrs. 2 mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? unknown

Did an operation precede death? no Date of: no

Was there an autopsy? no

What test confirmed diagnosis? sputum + Physical Exam

(Signed) R. J. Young, M. D.

, 19 (Address) 1424 E. Monument St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS 1302

John W. Henderson

9 Monument

N. B.—WRITE FULL NAME, ADDRESS, AND CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—1-10-21—M&T—1500 Bks.

D 60982 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓

D 60982

1-PLACE OF DEATH  
CITY OF BALTIMORE: (No. *370 S. Cayson* ST., *20* WARD)  
2-FULL NAME *Chas Bothner*  
(a) RESIDENCE NO. *370 S. Cayson* ST., WARD  
(Usual place of abode)  
Length of residence in city or town where death occurred *5* yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS  
3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *married*  
5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Carrie A. Smith*  
6 DATE OF BIRTH (month, day, and year) *May 16 1858*  
7 AGE Years *69* Months *10* Days *18* If LESS than 1 day, hrs. or min.  
8 OCCUPATION OF DECEASED  
(a) Trade, profession or particular kind of work *Salesman*  
(b) General nature of industry, business, or establishment in which employed (or employer) *Clothing Wfg*  
(c) Name of employer  
9 BIRTHPLACE (city or town) (State or country) *New Orleans*  
10 NAME OF FATHER *Chas Bothner*  
11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*  
12 MAIDEN NAME OF MOTHER *E. Eichelmann*  
13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14 Informant *Carrie A. Bothner*  
(Address) *370 S. Cayson St*

15 *FEB 5 - 1922* ROBERT B. KRAUTEN, Registrar  
Burial Permit *60982*

MEDICAL CERTIFICATE OF DEATH  
16 DATE OF DEATH (month, day, and year) *Feb 3 1922*  
17 I HEREBY CERTIFY, That I attended deceased from *July 2nd 1921* to *Feb 3rd 1922*, that I last saw him alive on *Feb 2nd 1922*, and that death occurred, on the date stated above, at *3 P. m.*  
The CAUSE OF DEATH\* was as follows:  
*Atherosclerosis*  
*Myocardial Insufficiency*  
(duration) *2* yrs. mos. ds.  
CONTRIBUTORY (Secondary) *Heart failure*  
(duration) yrs. mos. ds.  
18 Where was disease contracted if not at place of death?  
Did an operation precede death? *no* Date of  
Was there an autopsy? *no*  
What test confirmed diagnosis? *Phys Exam*  
(Signed) *Harry Goldberger* M. D.  
*2/4, 1922* (Address) *2210 Rutawo Pl*  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *New Orleans* DATE OF BURIAL *Feb 5 1922*  
FUNERAL ADDRESS *408 Mississippi St New Orleans*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 60983 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60983

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bayview Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 27 WARD)

2-FULL NAME

Joseph S. Baldwin

(a) RESIDENCE NO.

Groves, Md.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

1300 — mos.

How long in U. S., if of foreign birth?

ys. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1880

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.  
or min.

42

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Pharmacist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Maryland  
Unknown

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Unknown

14

Informant  
(Address)

Hospital Record  
Baptist Hospital

15

FEB 5 - 1922

ROBERT R. KRAUTER  
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4. 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 2, 1922, to Feb. 4, 1922

that I last saw him alive on Feb. 3, 1922

and that death occurred, on the date stated above, at 2:50 a.m.

The CAUSE OF DEATH\* was as follows:

Acute Myocardial Insufficiency

(duration) yrs. mos. ds.  
CONTRIBUTORY Cause of Death  
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Clinical findings

(Signed) A. J. Jodanis, M. D.

2/4/22 Address Bayview Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Glencoe Baltimore Md

2/6 1922

20 UNDERTAKER

ADDRESS

Chas. Evans & Son 1180 Mt. Royal Ave



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

60984

## CERTIFICATE OF DEATH.

90 D 60984

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 871 W. Lombard ST., 18 WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

(a) RESIDENCE NO. 871 W. Lombard ST., WARD

(Usual place of abode) Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Sloffer

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE Years 58 Months Days If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) Va  
(State or country)

10 NAME OF FATHER Fredrick Sloffer

11 BIRTHPLACE OF FATHER (city or town) Scotland  
(State or country)

12 MAIDEN NAME OF MOTHER Dout Kurr

13 BIRTHPLACE OF MOTHER (city or town) Dout Kurr  
(State or country)

14 Informant Jennie Sloffer  
(Address) 871 W. Lombard

15 FEB 5 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 19 22

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 19 22 to Feb 3, 19 22, that I last saw him alive on Feb 2, 19 22, and that death occurred, on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH\* was as follows:

Myocarditis

CONTRIBUTORY (Secondary) Cardiac Paresis  
(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? at his residence

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

(Signed) Chas A. Fetterhoff M. D.

19 (Address) 1807 W. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Landon Park DATE OF BURIAL Feb 6 19 22

20 UNDERTAKER Wm. C. Wicks ADDRESS 502 E. North

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

D 60985

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 N. Green St. 17 WARD)

2-FULL NAME Rosa Laberto

(a) RESIDENCE. NO. 410 N. Green St. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single Married Widowed, or Divorced (write the word) Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't know

7 AGE Years Months Days If LESS than 1 day, hrs. or min. Don't know date of birth

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't know

14

Informant (Address)

Charles Case, 40 N. East St.

15

Filed FEB 5 - 1922

ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1922, to Feb 3, 1922, that I last saw her alive on Feb 2, 1922, and that death occurred, on the date stated above, at 5:00 p.m.

The CAUSE OF DEATH\* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 410 N. Green

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. G. M. D.

Address 117 N. Van Ness St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral

7/6/22

20 UNDERTAKER

ADDRESS

George J. Ruth 1735 17th Ave.

OVER

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60986

## CERTIFICATE OF DEATH.

D 60986

1-PLACE OF DEATH *Womans Hospital*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST., *15* WARD)2-FULL NAME *Mrs Goldie Hackman*(a) RESIDENCE NO. *1918 Ridgewood Ave*

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Albert H. Hackman*6 DATE OF BIRTH (month, day, and year) *11-30-1895*7 AGE Years *26* Months *2* Days *5* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Home*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md*

10 NAME OF FATHER

*William Wortman*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Baltimore Md.*

12 MAIDEN NAME OF MOTHER

*Margaret Faber*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore Md*

14

Informant (Address)

*George Buzany 1918 Ridgewood Ave*

15

Filed

*FEB 5 - 1922*

ROBERT B. KRAUTER

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 4* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 31*, 1922, to *Feb 4*, 1922that I last saw her alive on *Feb 4*, 1922and that death occurred, on the date stated above, at *6:20 am*

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*(duration) yrs. mos. *2* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes*, Removal of retained placenta Date of *2-1-22*Was there an autopsy? *No*What test confirmed diagnosis? *Physical Diagnosis*(Signed) *E. Duman* M. D.*Feb 4*, 1922 (Address) *Womans Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Woodlawn Co.**2/7/22*

20 UNDERTAKER

ADDRESS

*George J. Duth... 35 Haystack Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60987

## CERTIFICATE OF DEATH.

47 D 60987  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621-Arguth ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ST. 9 WARD

WARD

(If non-resident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofWilliam Amos6 DATE OF BIRTH (month, day, and year) 12-10-1866

7 AGE

Years

Months

Days

If LESS than

551221 day...hrs.  
or...min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

Filed

FEB 5 - 1922

ROBERT B. KRAUTER,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1 19 22

17 I HEREBY CERTIFY that I attended deceased from

Sept. 15, 19 22, to Feb. 1, 19 22,that I last saw her alive on Feb. 18, 19 22,and that death occurred, on the date stated above, at 8:30 m.

The CAUSE OF DEATH\* was as follows:

Cancer of right lung  
(secondary to cancer of uterus)  
(wart) (duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) J. E. Brown M. D.(Address) 1531 E. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Holy Redeemer Ch. 7/6/22  
George J. Ruth 1735 Hayfield

N. B.—WRITE CAREFULLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-3-19—H. P. Co.—1000 Bks.

D 60988

HEALTH DEPARTMENT—CITY OF BALTIMORE 60988

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 409 Perry

ST. 22

WARD 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 409 Perry

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 20 / 84

7 AGE

Years

Months

Days

11 LESS than 1 day, hr., or min.

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

—

(c) Name of employer

—

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Amel Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Charlotte Matney

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Mrs. Stanley 409 Perry St

15

FEB 5 - 1922 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 2 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 20, 1921, to July 2, 1922

that I last saw her alive on July 1, 1922

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Urinalysis

(Signed) Dr. W. W. W. M. D.

(Address) 106 Edmondson

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

W. C. C. Cemetery

2/5 1922

20 UNDERTAKER

ADDRESS

Dr. W. W. W. 106 Edmondson

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60989

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1541 Covington ST. 24 WARD)

## 2-FULL NAME

Harriett A. Staylor

## (a) RESIDENCE. NO.

1541 Covington ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,

or Divorced (write the word)

5a If married, widowed, or divorced

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

FEB 6-1922

ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1922, to Feb 2, 1922

that I last saw her alive on Feb 2, 1922

and that death occurred, on the date stated above, at 11:15 P.M.

The CAUSE OF DEATH\* was as follows:

Acute Cardiac Dilatation

CONTRIBUTORY (Secondary)

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) Sidney H. Street, M.D.

2/5, 1922 Address 405 N. Charles St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park

Feb 6 1922

20 UNDERTAKER

ADDRESS

J. J. Fakery Sons

1818 Light St

Physicians should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60990

D 60990

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH

Woman's Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Lafayette &amp; John St. 14

WARD)

2. FULL NAME

Mrs Martha E. Jones

(a) RESIDENCE NO.

Ruxton Ind.

ST.,

WARD

Ruxton Md.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

9

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widow

5a If married, widowed or divorced

HUSBAND of

(or) WIFE of

Late

Robert L. Jones

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

about 69

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Kent Co Md

10 NAME OF FATHER

Robert M. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Kent Co Md

12 MAIDEN NAME OF MOTHER

M. E. Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Kent Co Md

14

Informant

(Address)

Mr Thomas C. Coleman

Ruxton Ind.

15

FEB 6 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 25, 1922, to Feb 3, 1922,

that I last saw her alive on Feb 3, 1922,

and that death occurred, on the date stated above, at 7:45 p.m.

The CAUSE OF DEATH\* was as follows:

Bronchial Pneumonia

(duration)

yrs.

mos.

3 ds.

CONTRIBUTORY (Secondary)

Ren hypertension for Cancer of uterus

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb 1, 1922

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. C. Ehlman, M. D.

2/3, 1922 (Address) Woman's Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cem Feb 6, 1922

20 UNDERTAKER

ADDRESS

Henry J. Jenkins &amp; Son Co

1200 N. E. St.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60991

## CERTIFICATE OF DEATH.

57

D 60991

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 137 N. Lakewood Ave. 6 ST. WARD)

## 2-FULL NAME

(a) RESIDENCE. NO. 137 N. Lakewood Ave. ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds.

How long in U. S., if of foreign birth? 55 yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie St. Volk.

6 DATE OF BIRTH (month, day, and year) April 16-1844

7 AGE Years 77 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

10 NAME OF FATHER Conrad Volk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Dorothea Parr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Minnie St. Volk (Address) 137 N. Lakewood Ave.

15 FEB 6 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3rd 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1922, to Feb 3, 1922, that I last saw him alive on Feb 3, 1922, and that death occurred, on the date stated above, at 7:45 P. M.

The CAUSE OF DEATH\* was as follows:

Hemiplegia 4 days  
Diabetes Mellitus  
Chronic Nephritis, Chronic  
Valvular Heart Disease  
CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? (Signed) E. H. Meyer Jr. M. D.

(Address) 2638 E. Baltimore St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Redeemer Cem.

20 UNDERTAKER

Lilly and Zick

DATE OF BURIAL

Feb. 7 1922

ADDRESS

403 S. Wolfe St.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60992

162 D 60992

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 341 S. Twelfth St. ST., 26 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Richard E. Stroll

## (a) RESIDENCE NO.

341 S. Twelfth St. ST., 26 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Jan. 8 - 1922

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

27

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

## 10 NAME OF FATHER

Raymond Stroll

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Muching

## 12 MAIDEN NAME OF MOTHER

Martha E. Miller

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Md.

## 14

Informant (Address)

Raymond Stroll  
341 S. Twelfth St.

## 15

Filed

FEB 6 - 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb 1, 1922, to Feb 4, 1922.that I last saw him alive on Feb 4, 1922.and that death occurred, on the date stated above, at 6.50 p.m.

The CAUSE OF DEATH\* was as follows:

Atelctasis(duration) yrs. mos. 27 ds.

## CONTRIBUTORY (Secondary)

Bronchopneumonia(duration) yrs. mos. 2 ds.

## 18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of noneWas there an autopsy? noWhat test confirmed diagnosis? none

(Signed)

Elbert W. Rosenthal, M. D.

Feb 6, 1922 (Address)

2446 Lakewood Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Oak Lawn Cem.

## DATE OF BURIAL

Feb 6 1922

## ADDRESS

403 S. Wolfe St.

## 20 UNDERTAKER

Lilly and Zile

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60993

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH 2523 East Biddle St.

CITY OF BALTIMORE: (No. 2525 East Biddle St.: 8 WARD)

2-FULL NAME Mary M. Knighton

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 2523 East Biddle St., 8 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 3 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

(or) WIFE of

Daniel V. Knighton

6 DATE OF BIRTH (month, day, and year) Oct 28 1878

7 AGE Years 43 Months 3 Days 4 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

John Nohman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Cecilia Volk

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Daniel V. Knighton Husband 2523 E. Biddle St.

15

FEB 6-1922

ROBERT H. KNAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1922

17

I HEREBY CERTIFY, That I attended deceased from July 4, 1921, to Feb 2, 1922, that I last saw her alive on Feb 2, 1922,

and that death occurred, on the date stated above, at 11:20 p. m.

The CAUSE OF DEATH\* was as follows:

Squamous Cell Carcinoma of Uterus

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Place of death

Did an operation precede death?

Yes Date of July 10/22

Was there an autopsy?

No

What test confirmed diagnosis?

Operation &amp; a

(Signed) C. W. McDonald, M. D.

Feb 4, 1922 (Address) 1540 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Cemetery Feb 6 1922

20 UNDERTAKER

ADDRESS

Robert J. Turner 1542 N. Broadway

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60994

## CERTIFICATE OF DEATH.

REGISTERED NO.

D 60994

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3620 Cedar Ave. ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Charles L. Stover

## (a) RESIDENCE. NO.

3620 Cedar Ave. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs.

mos.

ds.

How long in U. S. If of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

April 10, 1900

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

21 yrs.9 mos.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Balto, Md.

## 10 NAME OF FATHER

Alfred Stover

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Carrie Schaffer

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto, Md.

## 14

Informant (Address)

Carrie Stover  
3620 Cedar Ave

## 15

Filed

FEB 6 - 1922ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb. 3, 1922

## 17

HEREBY CERTIFY, That I attended deceased from

January 17, 1922, to Feb 3, 1922,that I last saw him alive on January 31, 1922,and that death occurred, on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH\* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Endocarditis - Myocarditis

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Mearns, M. D., 19 (Address) 4119 Falls Road

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Louder ParkFeb 6 1922

## 20 UNDERTAKER

## ADDRESS

Chenoweth & Son, Chestnut

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 60995

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60995

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Robert Garrett Hospital for Children

REGISTERED NO.

CITY OF BALTIMORE: (No.

27 N Carey

ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Charles Triplett

(a) RESIDENCE. NO.

2106 Herbert

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

8

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 17, 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

City

10 NAME OF FATHER

Charles Triplett

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Bessie Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant

Bessie Triplett

(Address)

2106 Herbert St

15

FEB 10 1922

ROBERT M. KRAUTER

Racial Record, Clinician

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 5 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 4 1922 to Feb 5 1922

that I last saw him alive on Feb 5 1922.

and that death occurred, on the date stated above, at 12:10 A. M.

The CAUSE OF DEATH\* was as follows:

Acidosis &amp; Malnutrition

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

J. W. Clift

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Marys Hospital Feb 7 1922

20 UNDERTAKER

Chenoweth &amp; Son Chestnut Ave

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assoc.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributor (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (mere symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Child only in hosp.  
short time before death.  
Badly nourished and  
practically moribund upon  
entrance into hosp.  
Rachitis primary No  
further history*

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60997

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen White(a) RESIDENCE. NO. UnknownST. 76 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown6 DATE OF BIRTH (month, day, and year) 18767 AGE Years Months Days If LESS than 1 day. hrs. or min. 45 -- -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co.,  
(State or country) Maryland10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown  
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)14 Informant Hospital Records,  
(Address) Municipal Hospital.15 Filed FEB 6 - 1922 J. E. White Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2 19 2217 I HEREBY CERTIFY, That I attended deceased from February 1, 19 22, to February 2, 19 22, that I last saw her alive on February 1, 19 22, and that death occurred, on the date stated above, at 4:45 A.M.  
The CAUSE OF DEATH\* was as follows:Cancer of uterusCONTRIBUTORY (Secondary) Hemorrhage into peritoneum  
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Autopsy

What test confirmed diagnosis?

(Signed) Edw. J. Neill M. D.2/2/1922 Address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

7th Auburn St

DATE OF BURIAL

Feb. 6 19 22

20 UNDERTAKER

J. E. Brown & Son 108 N. Montg

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 60998

## CERTIFICATE OF DEATH.

REGISTERED NO. C

60998

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2842 St Paul ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Lilias Watson McBready(Residence in Baltimore: No. 2842 St Paul St. St.; 58 yrs.,    mos.,    ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

## 6-DATE OF BIRTH,

Mar 21, 1856  
(Month) (Day) (Year)

## 7-AGE,

65 yrs., 2 mos., 16 ds.

If LESS than 1 day,

...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

wife 137  
at home

## 9-BIRTHPLACE, (State or Country),

New York City

## 10-NAME OF FATHER,

Geo Miller

## 11-BIRTHPLACE OF FATHER (State or Country),

Scotland

## 12-MAIDEN NAME OF MOTHER

Sarah Watson

## 13-BIRTHPLACE OF MOTHER (State or Country),

Scotland

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph L McBready(Address) 2842 St Paul St

## 15-

FEB 6 - 1922 ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Feb 4, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Dec 1921, to Feb 4 1922,that I saw her alive on Feb 4 1922,and that death occurred, on the date stated above, at 6 A.m.

The CAUSE OF DEATH\* was as follows:

Arterio-sclerosis

.....

.....

..... (Duration) 3 yrs., 4 mos.,    ds.

## CONTRIBUTORY (Secondary)

Acute Pulmonary edema..... (Duration) 1 hr.....(Signed) W J Love M. D.Feb 5, 1922 (Address) 836 W. North A

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death    yrs.,    mos.,    ds. In the State    yrs.,    mos.,    ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Mount Ridge Cem

## DATE OF BURIAL,

Feb 7, 1922

## 20-UNDERTAKER

W M Rontson

## ADDRESS

2235 N. North

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

60999

## CERTIFICATE OF DEATH

REGISTERED No. 60999

PLACE OF DEATH

CITY OF BALTIMORE (No. 3626 Beech Ave. ST. 13 WARD)

FULL NAME Augustus Reinhardt.

(Residence in Baltimore: No. 3626 Beech Ave. ST. 13 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-STATUS Widowed (Write the word)

6-DATE OF BIRTH July 26, 1852 (Month) (Day) (Year)

7-AGE 64 yrs. 6 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work none (b) General nature of industry, business, or establishment in which employed (or employer) cod

9-BIRTHPLACE (State or country) Balto. Md.

10-NAME OF FATHER Charles C. Reinhardt 11-BIRTHPLACE OF FATHER Germany. 12-MAIDEN NAME OF MOTHER Margaret Erney. 13-BIRTHPLACE OF MOTHER York. Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Stella G. Williams (Address) 3626 Beech Ave

FEB 6 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Feb 7th, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 12, 1922, to Feb 7, 1922, that I saw him alive on Jan 30th, 1922, and that death occurred, on the date stated above, at 1 P. m. The CAUSE OF DEATH\* was as follows:

Left hemiplegia -

(Duration) yrs. mos. 23 ds

Contributory (SECONDARY) Arterio sclerosis.

(Signed) Mary S. McCarty, M. D. (Address) 57 W. Preston St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL London Park DATE OF BURIAL 2/7, 1922

20-UNDERTAKER William Cook ADDRESS 502 E North

*Not apoplectic. Due to thrombosis*

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*,

*meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

<i>Abortion,</i>	<i>Hæmorrhage,</i>	<i>Meningitis,</i>	<i>Phlebitis,</i>
<i>Cellulitis,</i>	<i>Gangrene,</i>	<i>Miscarriage,</i>	<i>Pyæmia,</i>
<i>Childbirth,</i>	<i>Gastritis,</i>	<i>Necrosis,</i>	<i>Septicæmia,</i>
<i>Convulsions,</i>	<i>Erysipelas,</i>	<i>Peritonitis,</i>	<i>Tetanus,</i>

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved): *Suicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to the same.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61000

D 61000

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3023 Westwood Ave. 15

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

(a) RESIDENCE No. 3023 Westwood Ave.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth

WARD

(If non-resident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

FEB 6 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

January 3, 1922, to February 4, 1922, that I last saw her alive on February 4, 1922

and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? 3023 Westwood Ave.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jm Conrad Boyle, M. D.

19 (Address) 1900 Maryland Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr. Boyle 1900 Md. Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 61001

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

1311

CITY OF BALTIMORE: (No.

1311

E Biddle St. WARD

2-FULL NAME

Anna Kutt.

(a) RESIDENCE NO.

1311 E Biddle St.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

50

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single.

6 DATE OF BIRTH (month, day, and year)

April 7, 1865

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

56

9.

28.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

12

(c) Name of employer

Oppenheim & Abendorff

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md. Baltimore County.

10 NAME OF FATHER

John Kutt.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany.

12 MAIDEN NAME OF MOTHER

K. Schaffer.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany.

14

Informant (Address)

Anna Kutt. 1311 E Biddle St.

15

FEB 6 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

2/5/22

17

I HEREBY CERTIFY, That I attended deceased from February 2, 1922, to February 5, 1922, that I last saw him alive on 4:45 AM 1922.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

(Urgina procteria)

CONTRIBUTORY (Secondary)

(duration)

2 yrs.

mos.

ds.

Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Feb. 6, 1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St. Hermann

2/7 1922

20 UNDERTAKER

ADDRESS

Emmanuel Lem

324 Bk



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61002

## CERTIFICATE OF DEATH.

D 61002

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 E 30th ST.: 9 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Aluira Wahl(a) RESIDENCE. NO. 908 E 30th ST.: 9 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds.How long in U. S., if of foreign birth? — yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) married

6 If married, widowed, or divorced

(or) WIFE of Edward Wahl6 DATE OF BIRTH (month, day, and year) Feb 2-18807 AGE Years 41 Months 11 Days 2 If LESS than 1 day, — hrs. or — min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa10 NAME OF FATHER Eugene Woodward11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa12 MAIDEN NAME OF MOTHER Eugenia G. Dunslop13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa14 Informant Dr. F. J. ... (Address) 2631 N. Calvert St.

15 FEB 6 - 1922

ROBERT A. ... Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 192217 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1922, to Feb 4, 1922, that I last saw him alive on Feb 4, 1922, and that death occurred, on the date stated above, at 5:57 P. M.

The CAUSE OF DEATH\* was as follows:

(Pneumonia)(duration) yrs. mos. 5 ds.CONTRIBUTORY miscellaneous (Secondary)(duration) yrs. 4 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of Feb 1-1922Was there an autopsy? noWhat test confirmed diagnosis? Phys sign + culture(Signed) Dr. F. J. ... M. D.19 (Address) 2631 N. Calvert St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore CemeteryFeb 7th 1922

20 UNDERTAKER

ADDRESS

Rev Schilling & Sons1126 E. Monument St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 61003

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 735 Sarah am,

St. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lawrence Bolden

(Residence in Baltimore: No. 735 Sarah am.

St. 3 yrs., mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

Don't know, 1 (Month) (Day) (Year)

7-AGE,

24 yrs., mos. da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer, 040

9-BIRTHPLACE, (State or Country).

Ga

10-NAME OF FATHER,

Don't know

11-BIRTHPLACE OF FATHER (State or Country).

Don't know

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER (State or Country).

Don't know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Estor

(Address) 916 Pa

15-

Filed

FEB 6 1922

ROBERT H. KRAUTER,

Burial Permit

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Feb 4, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

...and that said deceased came to his death (Inquest, au-

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Valvular disease of the heart. Don't know (Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Don't know (Duration) yrs. mos. da.

(Signed) H. H. Grunich M. D. (Coroner)

2-61, 1922 Address 117 W. Saratoga

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. mos. da. State... yrs. mos. da. In the

Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL,

St. Paul's

DATE OF BURIAL,

Feb 6, 1922

20-UNDERTAKER

Daniel Estor

ADDRESS

916 Pa

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61004

## CERTIFICATE OF DEATH.

D 61004

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

409 Calvin  
William Stevenson  
409 Calvin

ST.

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

8-LESS than 1 day, hrs. or min.?

9-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

10-BIRTHPLACE, (State or Country),

11-NAME OF FATHER,

12-BIRTHPLACE OF FATHER (State or Country),

13-MAIDEN NAME OF MOTHER

14-BIRTHPLACE OF MOTHER (State or Country),

15-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Ella Stevenson

(Address) 409 Calvin St

16-

17-

18-ROBERT R. KRAUTER

### CORONER'S CERTIFICATE OF DEATH.

19-DATE OF DEATH,

(Month) (Day) (Year)

20-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

And that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis

(Duration) yrs. mos. ds.

21-CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

1012 (Address) 1059 Rue

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

22-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

23-Former or usual residence

24-PLACE OF BURIAL OR REMOVAL.

25-DATE OF BURIAL.

26-UNDERTAKER

27-ADDRESS

Cathedral Feb 7, 1922  
J. C. Wiedefeld 914 Greenfield

D 61005

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61005

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *228 W. Lafayette* WARD)2-FULL NAME *Charles Meyer*(a) RESIDENCE. No. *228 W. Lafayette* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *70* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widower*

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

*Mary C. Meyer*6 DATE OF BIRTH (month, day, and year) *Dec 6 1840*7 AGE Years *81* Months *1* Days *29* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Incas 086*(b) General nature of industry, business, or establishment in which employed (or employer) *Johns Hopkins University*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Ohio*10 NAME OF FATHER *Frederick A. Meyer*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Felma Kriedner*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*14 Informant *Carl S. Meyer* (Address) *Pa*15 Filed *FEB 6 1922*ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 4, 1922*17 I HEREBY CERTIFY, That I attended deceased from *1916* to *Feb 4, 1922*, that I last saw him alive on *Feb 2, 1922*, and that death occurred, on the date stated above, at *7 A.* m.

The CAUSE OF DEATH\* was as follows:

*Epithelioma of face -*(duration) *6* yrs. - mos. - ds.CONTRIBUTORY (Secondary) *Debility -*(duration) - yrs. *6* mos. - ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *None*(Signed) *Chas. W. Arnold*, M. D., 19 (Address) *1327 Ark Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Green Mount* *Feb 6, 1922*

20 UNDERTAKER ADDRESS

*H. C. Wiedefeld 914 Green Mount Ave*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61006

## CERTIFICATE OF DEATH.

D 61006

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Little Sisters of the Poor, St. 10* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Fred Steggeman*(a) RESIDENCE. NO. *Preston Valley No. 1* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *8<sup>th</sup> February 1853*7 AGE Years *68* Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Carpenter*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Md.*10 NAME OF FATHER *John Steggeman*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *Margaret Swartz*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant *Sister Florence* (Address) *Preston Valley*15 Filed *FEB 6 1922* ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 4 1922*17 I HEREBY CERTIFY, That I attended deceased from *to record* 19 *to* 19 *to*that I last saw him alive on *July 29 1922*and that death occurred, on the date stated above, at *4:15 P. M.*

The CAUSE OF DEATH\* was as follows:

*Valvular disease of heart**Unknown* (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *F. U. Warner*, M. D.5, 1922 (Address) *1133 Valley St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Holy Redeemer Feb 7- 1922*

20 UNDERTAKER ADDRESS

*H. C. Windefield 914 Greenmount*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61007

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1618 Ramsey St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Wilaveria Thurman

(Residence in Baltimore: No. 1601 Ramsey St.; yrs. .... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, white 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, Nov 20, 1869  
(Month) (Day) (Year)

7-AGE, 52 yrs. 2 mos. 14 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work... House work  
(b) General nature of industry, business, or establishment in which employed (or employer)... at home 037

9-BIRTHPLACE, (State or Country), Germany

10-NAME OF FATHER, Bernard Zinkand

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Helena Smith

13-BIRTHPLACE OF MOTHER, (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph H. Thurman

(Address) 1901 Ramsey St

15- **FEB 6 - 1922** ROBERT R. KRAUTER,  
Filed City of Baltimore

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 3, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said Inquest find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Angina Pectoris

(Duration) ... yrs. 9 mos. ... ds.  
CONTRIBUTORY acute congestive lungs  
(Secondary) failure

(Signed) James M. Reuther M. D.  
(Coroner.)

Feb 3, 1922. (Address) 700 E. Chase St

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death... yrs. .... mos. .... ds. In the State... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Cathedral Cemetery Feb 7, 1922

20-UNDERTAKER, ADDRESS

Knell & Son 1727 W. Pratt St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61008

## CERTIFICATE OF DEATH.

D 61008

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 Maryland ST., 25 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

(a) RESIDENCE NO. 529 Maryland ST., 25 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 1

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Aug 9, 1903

## 7 AGE

Years

Months

Days

If LESS than  
1 day, .... hrs.  
or .... min.18525

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Canada

## 10 NAME OF FATHER

Elyse Segne'

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Canada

## 12 MAIDEN NAME OF MOTHER

Marie Castonguay

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Canada

## 14

Informant  
(Address)J. A. Valade

## 15

Filed 1922, 19ROBERT F. KRAUTER,  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1922

## 17

I HEREBY CERTIFY, That I attended deceased from  
Feb 2, 1922, to Feb 3, 1922.that I last saw him alive on Feb 2, 1922.and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. Brooks M. D.19 (Address) Brooklyn Me\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Mount Canada

DATE OF BURIAL

2/6/22

20 UNDERTAKER

Margaret Flynn

ADDRESS

14 Wright St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 61009

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3613 Cottage av ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur E. Laverty

(a) RESIDENCE. No. 3613 Cottage av WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX m. 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Adam Laverty

6 DATE OF BIRTH (month, day, and year) June 17, 1884

7 AGE Years 38 Months 7 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturer 086

(b) General nature of industry, business, or establishment in which employed (or employer) Wholeshipping

(c) Name of employer Self

9 BIRTHPLACE (city or town) Pittsburg Pa. (State or country)

10 NAME OF FATHER Charles E. Laverty

11 BIRTHPLACE OF FATHER (city or town) Wisconsin (State or country)

12 MAIDEN NAME OF MOTHER Helen Frank

13 BIRTHPLACE OF MOTHER (city or town) Wisconsin (State or country)

14 Informant Mrs Helen Laverty (Address) 3613 Cottage av

15 FEB 6 - 1922 ROBERT R. KRAUTER Registrar  
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-5-1922

17 I HEREBY CERTIFY, That I attended deceased from

Jan. 30, 1922, to Feb 5, 1922,

that I last saw him alive on Feb 6, 1922,

and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted unknown  
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) James S. Aschurst, M. D.

(Address) 4012 Park Heights av

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Landow Park DATE OF BURIAL Feb 7 1922

20 UNDERTAKER C. F. McCormick ADDRESS St. Landow



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH  
D 61010

CITY OF BALTIMORE: (NO. 7 ST.; WARD)

2-FULL NAME

Wm. H. Gaines

(a) RESIDENCE. No.

Aberdeen, Md. ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

unknown

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or, WIFE of)

Fannie Gaines

6 DATE OF BIRTH (month, day, and year)

Feb 4 - 1855

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

66

11

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Minister 018

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

John H. Gaines

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Nancy Glenn

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14

Informant (Address)

JOHNS HOPKINS HOSPITAL.

15

6661-9833

ROBERT R. KRAUTER

Burial Permit Clerk.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 5 - 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 23<sup>rd</sup>, 1922, to Feb. 5<sup>th</sup>, 1922

that I last saw him alive on Feb. 5<sup>th</sup>, 1922

and that death occurred, on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency

(duration) 6 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Arteriosclerosis

Hypertension (duration) unknown yrs. mos. ds.

18 Where was disease contracted

if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Exam X-ray

(Signed) Francis R. Diemaid, M. D.

Feb. 5, 1922 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Home de France Md. 2-6 1922

20 UNDERTAKER

Ed B. Hader 115 E. West St.

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 61011 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2025 W. Lexington St. ST. 70 WARD)

2-FULL NAME

Temperence Catherine Biddinger

(a) RESIDENCE No. 2025 W. Lexington St. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

John J. Biddinger

6 DATE OF BIRTH (month, day, and year) Jan. 12" 1855

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
67 0 22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co.  
(State or country) Md.

10 NAME OF FATHER John R. Sutch

11 BIRTHPLACE OF FATHER (city or town) Balto. Co.  
(State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Bowen

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.  
(State or country) Md.

14 Informant John E. Biddinger  
(Address) 3025 Presbury St.

15 FEB 6 - 1922 ROBERT R. KRAUTER,  
Burial Permit Clerk,

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3" 19 22

17

I HEREBY CERTIFY, That I attended deceased from Nov 18, 19 21, to Feb 3, 19 22.

that I last saw him alive on Feb 3, 19 22,

and that death occurred, on the date stated above, at 2.40 P. M.

The CAUSE OF DEATH\* was as follows:

Myocardial Infarction (Chronic)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilatation of Heart and Coronary Arteries (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Walter E. Biddinger, M. D.

Feb 3" 19 22 Address 2002 W. Lexington St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Paul's Chapel Md. Feb 6 19 22

20 UNDERTAKER

Joseph B. Cook 113 N. Balto. St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 61012

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 WARD)

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

ST.

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

FEB 6 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted? if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Venous puncture

(Signed) Grace G. Stewart M. D.

(Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING  
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ 21 day  
20038 Monument  
74-001 D 61013

D 61013

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 South Linwood ST., 1 WARD)

2-FULL NAME Anna C. Grimes

(a) RESIDENCE NO. 505 South Linwood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Edward Grimes

6 DATE OF BIRTH (month, day, and year) 1/8/68

7 AGE Years 53 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Norfolk Va (State or country)

10 NAME OF FATHER William Anderson

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OR MOTHER Mary Schmidt

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14

Informant (Address)

Guarretta Moran 505 S. Linwood

15

FEB 6 - 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 4, 1922, to February 4, 1922,

that I last saw him alive on February 4, 1922,

and that death occurred, on the date stated above, at 2:15 a m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage (apoplexy)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Frank J. Ayd

M. D.

Feb 5, 1922 (Address) 2085 E. Monument St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20038 Monument St. Oakliff Cemetery

2/7 1922

20 UNDERTAKER

William Cook

ADDRESS

502 E North



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61014

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61014

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. 2104 E. Monument)

2-FULL NAME

Sarah A. Reed

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2104 E. Monument)

St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.

Married

6-DATE OF BIRTH

1846

7-AGE

75

10-LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE (State or Country).

Virginia

10-NAME OF FATHER

James M. Murphy

11-BIRTHPLACE OF FATHER (State or Country).

Virginia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country).

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Martha Sigel  
811 N. Montford Ave.

15-

File

FEB 6 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Feb. 4, 1922

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

And that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Senility

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) M. D.

2-6-22 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Baltimore

DATE OF BURIAL

Feb 6, 1922

20-UNDERTAKER

William Cook

ADDRESS

502 E. North Ave.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61015

## CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4404 St. George Ave.)

## 2-FULL NAME

(a) RESIDENCE, NO. 4404 St. George Ave.

(Usual place of abode)

Length of residence in city or town where death occurred 3/ yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Coe

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of

Annie Goodman

6 DATE OF BIRTH (month, day, and year)

April 24, 1890

7 AGE

34

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Harmon Lubom

(b) General nature of industry, business, or establishment in which employed (or employer)

Job work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore City

10 NAME OF FATHER

Harry Goodman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Sophie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14 Informant

(Address)

Margaret E. Smith, 3404 St. George Ave.

15

FEB 6 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3, 1922

17 I HEREBY CERTIFY, That I attended deceased from

Feb 3, 1922, to Feb 3, 1922,

that I last saw him alive on Feb 3, 1922,

and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH\* was as follows:

Organic Heart Disease

Not known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Expt. pain dead

(Signed) Samuel A. Bann M. D.

19 (Address) 937 Madison Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Zion Cemetery

DATE OF BURIAL

Feb. 7, 1922

ADDRESS

Fullerton Rd

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61016

## CERTIFICATE OF DEATH.

D 61016

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

1 yrs.

3 mos.

25 ds.

How long in U. S., if of foreign birth?

WARD.

(If nonresident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed FEB 6 - 1922 ROBERT R. KRAUTER Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 20, 1922, to Feb 5, 1922, that I last saw her alive on Feb. 5, 1922

and that death occurred, on the date stated above, at 8:45 P. M.

The CAUSE OF DEATH\* was as follows:

Laryngeal diphtheria

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 17 ds.

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cultures pos.

(Signed) B. Macfarlane

2/6/22 address Sydenham Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 61017

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61017

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

Robt Garrett Hosp for Children

REGISTERED NO.

CITY OF BALTIMORE: (NO.

27 N Carey

ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Clarence Baldwin

(a) RESIDENCE. No.

2131 Hollins

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec. 6 - 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

One

29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md

10 NAME OF FATHER

Clarence R. Baldwin

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md

12 MAIDEN NAME OF MOTHER

Justina Boone

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md

14

Informant (Address)

Clarence R. Baldwin Jr 2131 Hollins

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 5 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 27, 1922 to Feb 5, 1922 that I last saw him alive on Feb 5, 1922.

and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH\* was as follows:

Septicaemia (following nursing abscessed breasts.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

Physical Exam

(Signed)

J. H. T. Clift M. D. 27 N Carey

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Western Cemetery

DATE OF BURIAL

Feb 6 1922

20 UNDERTAKER

Geo. L. Schwal

ADDRESS

2101 E. 1st Ave

FEB 6 - 1922



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

38 D 61018

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* WARD)

## 2. FULL NAME

*Baby Woods (a) (Twin)*

## (a) RESIDENCE NO.

*2022 Brunt*

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*Black*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*0*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Feb 2, 1922*

## 7 AGE

Years

Months

Days

If LESS than 1 day, 1 hrs. or 0 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Baltimore*

## 10 NAME OF FATHER

*Chester Woods*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Virginia*

## 12 MAIDEN NAME OF MOTHER

*Mabel Palmer*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Virginia*

## 14

Informant (Address)

*Johns Hopkins Hospital**FEB 6 - 1922**ROBERT R. KRAUTER,**Burial Permit Clerk Registrar*

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*Feb 2 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*Feb 2 1922, to Feb 2 1922*that I last saw him alive on *Feb 2 1922*and that death occurred, on the date stated above, at *8:48 p.m.*

The CAUSE OF DEATH\* was as follows:

*Congenital Syphilis  
Prematurity*

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? *✓* Date of *✓*Was there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *H. Coathall* M. D.. 19 (Address) *Johns Hopkins Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

*JOHNS HOPKINS HOSPITAL*

## DATE OF BURIAL

*FEB 6 - 1922*

## 20 UNDERTAKER

*Commissioner Health.*

## ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61019

## CERTIFICATE OF DEATH.

38 D 61019

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital 14 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

(a) RESIDENCE No. 2023 Brown St ST., 14 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) 1

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 3, 19227 AGE Years Months Days If LESS than 1 day, 0 hrs. or 0 min. 0 0 0

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Charles Woods11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia12 MAIDEN NAME OF MOTHER Mabel Palmer13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia14 Informant Johns Hopkins Hospital (Address) Second15 FEB 6 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 19 22

17 I HEREBY CERTIFY, That I attended deceased from

Feb 2, 19 22 to Feb 2, 19 22that I last saw him alive on Feb 2, 19 22and that death occurred, on the date stated above, at 7:50 p.m.

The CAUSE OF DEATH\* was as follows:

Dysphagia (Congenital)  
Prematurity  
(duration) 1 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 1 Date of 1Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. H. Caldwell M. D., 15 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL DATE OF BURIAL FEB 6 - 192220 UNDERTAKER Commissioner of Health, ADDRESSCommissioner of Health,  
Johns Hopkins Hospital

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 61020 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61020

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3rd. Ave. & 4th. St. Fairfield. 25 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... John King. (C)

(Residence in Baltimore: No. 3rd. Ave. & 4th. St. Fairfield. St.; yrs. .... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX..... Male. 4-COLOR OR RACE..... Colored. 5-Single, Married, Widowed, or Divorced, (Write the word.)..... Widower

6-DATE OF BIRTH..... Do not know. 1..... (Month) (Day) (Year)

7-AGE..... 35 yrs. .... mos. .... ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work..... Pool room (b) General nature of industry, business, or establishment in which employed (or employer)..... proprietor.

9-BIRTHPLACE, (State or Country),..... Albany, Ga.

10-NAME OF FATHER..... Do not know. 11-BIRTHPLACE OF FATHER, (State or Country),..... Do not know. 12-MAIDEN NAME OF MOTHER..... Do not know. 13-BIRTHPLACE OF MOTHER, (State or Country),..... Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. R. Boykin. (C) brother in law. (Address) 1618 N. Calhoun St.

15- FEB 6 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH..... February 2nd. 1922. 192..... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cerebral Apoplexy.

CONTRIBUTORY (Secondary)

Duration) .... yrs. .... mos. .... ds. (Signature) Otto W. Reinhardt M. D. (Coroner) Feb. 5th 1922 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death.... yrs. .... mos. .... ds. In the State.... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Mt Auburn Feb 6 1922

20-UNDERTAKER, ADDRESS P. B. Gross 1400 McIlhenny

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61021

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2576 Residence ST. 14 WARD)

2-FULL NAME Carolene K Summerhughes

(4) RESIDENCE No. 2376 Kullerdown Rd. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 4 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
-------	-----------------	--

16 DATE OF DEATH (month, day, and year) *Feb. 6* 19*22*

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10<sup>th</sup>, 1922, to Feb 4<sup>th</sup>, 1922, that I last saw her alive on Feb. 4<sup>th</sup>, 1922

6 DATE OF BIRTH (month, day (and year) Jan 20/84

and that death occurred, on the date stated above, at 9 12 m.

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs or .....min.
	77	4	15	

The CAUSE OF DEATH\* was as follows:

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) **Name of employer**

**9 BIRTHPLACE** (city or town)  
(State or country)

10 NAME OF FATHER

II BIRTHPLACE OF FATHER (city or town)  
(State or country) Mer

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

**Informant**  
**(Address)**

19

•

Robert P. Harrison, and P.

## Registrar

17 I HEREBY CERTIFY, That I attended deceased from  
Jan. 10<sup>th</sup>, 1922, to Feb. 4<sup>th</sup>, 1922,  
that I last saw her alive on Feb. 4<sup>th</sup>, 1922,  
and that death occurred, on the date stated above, at 8 P. m.  
The CAUSE OF DEATH\* was as follows:

Infectious Myocarditis  
due to Hypostatic Pneumonia

CONTRIBUTORY *Dermatitis & Chronic*  
(Secondary) *infectious* (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? *Chronic*

Did an operation precede death? no Date of           

Was there an autopsy?..... *No.*

What test confirmed diagnosis? Yes

(Signed) Genevieve V. Zimmerman, M. D.

7/27/1977 (Address) 1805 W North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL	DATE OF BURIAL
---	----------------

<b>* UNDERTAKER</b>	<b>ADDRESS</b>

7/17/1944

**Bureau Permit Clerk.**



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61022

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (Municipal Tuberculosis Hospital) WARD)

2-FULL NAME Richard G. Lewis

(a) RESIDENCE. No. 314 W. Mulberry St. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE Years 56 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pressman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown  
9 BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland

10 NAME OF FATHER James M. Lewis

11 BIRTHPLACE OF FATHER (city or town) Maryland  
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Collander

13 BIRTHPLACE OF MOTHER (city or town) Maryland  
(State or country)14 Informant Hospital Records  
(Address) M.T.H.

15 Filed FEB 6 - 1922 J. E. Hahn Registrar

REGISTERED NO. 431 D 61022

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3. 1922

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1920, to Feb. 3, 1922,

that I last saw him alive on Feb. 3, 1922.

and that death occurred, on the date stated above, at 4.50 p. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. 5 mos. ds.

CONTRIBUTORY Tuberculous enteritis  
(Secondary) (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum. X-ray  
(Signed) Francis L. DeAngelis, M.D.

2-4-22 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Country Feb 7 1922

20 UNDERTAKER ADDRESS  
Walter W. Shriver, 1018 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 61023 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61023

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1126 Cathedral* ST., *11* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Hugh F. Parker*(a) RESIDENCE NO. *1126 Cathedral* ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *75* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

*Hannah E. Parker*6 DATE OF BIRTH (month, day, and year) *Dec 14 1846*7 AGE Years *75* Months *1* Days If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Md*10 NAME OF FATHER *Wm Parker*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *England*12 MAIDEN NAME OF MOTHER *Maria Miller*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Md*14 Informant *Hugh F. Parker* (Address) *1126 Cathedral St*15 Filed *Robert P. Harrison,* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2-5-1922*17 I HEREBY CERTIFY, That I attended deceased from *Feb 4*, 19*22*, to *Feb 5*, 19*22*.that I last saw him alive on *Feb. 3*, 19*22*.and that death occurred, on the date stated above, at *12 noon* m.

The CAUSE OF DEATH\* was as follows:

*Ischemic - > infarct  
myocarditis*CONTRIBUTORY (Secondary) *Pulmonary Oedema* (duration) *3* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis *True*(Signed) *J. Montindale*, M. D., 19 (Address) *1 E. Pratt St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Balto Cemetery Feb. 8 1922*

20 UNDERTAKER

ADDRESS

*Wm Cook 505 E. Parkers*

FEB 6-1922

Burial Permit Clerk

Information should be carefully supplied. Cause of Death in plain terms, so that it may be properly classified. Exact statement of Cause of Death is very important. See instructions on back of certificates.



N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61025 HEALTH DEPARTMENT—CITY OF BALTIMORE  
31 D 61025  
CERTIFICATE OF DEATH.

PLACE OF DEATH  
CITY OF BALTIMORE (No. 136 Preston St. 11 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
FULL NAME Alice Sims  
(Residence in Baltimore: No. 136 Preston St.; yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female 4-COLOR OR RACE, colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single  
6-DATE OF BIRTH, April 23, 1897 (Month) (Day) (Year)  
7-AGE, 25 yrs. 11 mos. 11 ds. If LESS than 1 day, hrs. or min.  
8-OCCUPATION: (a) Trade, profession, or particular kind of work, cook (b) General nature of industry, business, or establishment in which employed (or employer).  
9-BIRTHPLACE, (State or Country), Balt. Md.  
10-NAME OF FATHER, John Sims  
11-BIRTHPLACE OF FATHER, (State or Country), Md.  
12-MAIDEN NAME OF MOTHER, Annie Jennifer  
13-BIRTHPLACE OF MOTHER, (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. Sims  
(Address) 136 Preston

15-Filed FEB 6 - 1922 Robert P. Harrison, 101 Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 4, 1922 (Month) (Day) (Year)  
17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
Pulmonary tuberculosis  
(Duration) yrs. 4 mos. ds.  
CONTRIBUTORY (Secondary)  
(Duration) yrs. mos. ds.  
(Signed) J. T. Hennessy M. D. (Coroner.)  
Feb. 6, 1922 (Address) 2003 Eastman Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER, Johns Hopkins Hospital, ADDRESS, FEB 6 - 1922

Commissioner Health,

Prof. Wm. L. Woodruff



D 61026

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61026

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1615 Harmon* WARD)2-FULL NAME *Mary C. McConnell*(a) RESIDENCE. No. *1615 Harmon* ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *1* yrs. *11* mos. *27* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED No. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb 4 - 1880*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balti Md.*10 NAME OF FATHER *James McConnell*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balti Md.*12 MAIDEN NAME OF MOTHER *Josephine Gattis*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balti Md.*

14

Informant (Address) *James McConnell 1615 Harmon*

15

Filed *Robert P. Harrison,*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 5 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 2* 19 *22* to *Feb 5* 19 *22*that I last saw him alive on *Feb 5* 19 *22*and that death occurred, on the date stated above, at *2 P.* m.

The CAUSE OF DEATH\* was as follows:

*Over*  
*Brachio Pneumonia*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death? *No*Did an operation precede death? *No*

Date of

Was there an autopsy? *No*What test confirmed diagnosis? *Chemical*(Signed) *W. H. Campbell*

M.D.

Address *1644 Hanover*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Cross Cemetery**Feb 7 1922*

20 UNDERTAKER

Address *7 E. N. D.**F. A. Krause & Son**703 Hanover*

EB 6

1922

Burial Permit 61026

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A STATISTICAL RECORD. INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior.*

61027

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1116 1/2 E. Lexington ST.: 5 WARD)

## 2-FULL NAME

James E. Reynolds

## (a) RESIDENCE

No. 1116 1/2 E. Lexington ST.: 5 WARD.

(Usual place of abode)  
Length of residence in city or town where death occurred 43 yrs. mos. ds.(If nonresident give city or town and State)  
How long in U. S. If of foreign birth? 43 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7 AGE 43 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

FEB 7 - 1922

ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 23, 1922, to Feb. 6, 1922, that I last saw him alive on Feb. 5, 1922, and that death occurred, on the date stated above, at 4:29 a.m.

The CAUSE OF DEATH was as follows:

Influenza

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Acute bronchitis

18 Where was disease contracted if not at place of death? Balt. Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. H. Johnson, M. D.

Address 1520 E. Monument St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

Chris. H. Johnson 45 N. Caroline

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61028

D 61028

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *German Aged Home* ST. *70* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Margaret B. Noker*(a) RESIDENCE. NO. *German Aged Home* ST. *70* WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *30* yrs. mos. ds. How long in U. S., if of foreign birth? *30* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Widowed*

6 DATE OF BIRTH (month, day, and year)

*March 15 1841*

7 AGE

*80*

Years

Months

*10*

Days

*21*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baden Germany.*10 NAME OF FATHER *Adams G. Noker*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Baden Germany*12 MAIDEN NAME OF MOTHER *Anna M. Metzger*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baden Germany*

14

Informant

(Address)

*German Aged Home Records, Balto and Payson Sts.*

15

FEB 7 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 5* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 3rd* 19*22*, to *Feb. 5th* 19*22*.that I last saw her alive on *Feb. 5th* 19*22*.and that death occurred, on the date stated above, at *5 P.* m.

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia.*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *John H. Houff* M. D., 19 (Address) *1143 7th St. N.W.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Baltimore Cemetery**Feb. 7* 19*22*

20 UNDERTAKER

*Joseph B. Cook*

ADDRESS

*1033 N. Balto St.*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61029

## CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital

ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Richard C. Lorraine

(Residence in Baltimore: No. 303 Club Road, Roland Park

St. 8 yrs. 8 mos. 8 ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)  
Married

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

Abt. 38

YRS.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Vice-President

(b) General nature of industry, business, or establishment in which employed (or employer). Morrison Coke & Coal Co.

9-BIRTHPLACE,

(State or Country),

Staunton, Va.

10-NAME OF FATHER,

Mr. Lorraine

11-BIRTHPLACE OF FATHER

(State or Country),

Richmond, Va.

12-MAIDEN NAME OF MOTHER

Edmonia Mitchell

13-BIRTHPLACE OF MOTHER

(State or Country),

U. S.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

J. R. Callum

(Informant)

1700 W. Ghent Blv.

(Address)

Norfolk Va.

15-

Filed FEB 7 1922 ROBERT H. KRAUTER

Registrar.

Burial Permit Clerk.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

February

4th

1922

191

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

opsy or inquiry.) and that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Struck by pistol shot  
wound on  
head  
Friday (Duration) 1 hr. mos. 8 ds.

CONTRIBUTORY

(Secondary)

Meningitis

(Duration)

YRS.

mos.

ds.

(Signed)

W. H. Bailey

(Coroner.)

M. D.

Feb. 6<sup>th</sup>, 1922 (Address) 1650 B. Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

Friday

In the

of death

YRS.

mos.

ds.

State

YRS.

mos.

ds.

Where was disease contracted, if not at place of death.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Landon Park Cem

DATE OF BURIAL

Feb. 7<sup>th</sup>, 1922

20-UNDERTAKER

Joseph B. Cook

ADDRESS

1003 N. Baltimore St.

D 61030 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61030

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital 17 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Mason(a) RESIDENCE No. 1141 Myrtle ave.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofBeal H. Mason6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Unknown12 MAIDEN NAME OF MOTHER Elizabeth Wright13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country) Maryland14 Informant Hospital Records  
(Address) M.T.H.15 FEB 7-1922 ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4, 192217 I HEREBY CERTIFY, That I attended deceased from  
January 1, 1922, to Feb. 4, 1922.that I last saw her alive on Feb. 4, 1922.and that death occurred, on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(duration) yrs. 4 mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
If not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray(Signed) Francis J. Dada M. D.  
1-4-22 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

mt duburn cemetery Feb 7- 22

20 UNDERTAKER ADDRESS

John H. Todd 142 Hill St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ADDRESS

D 61032

Spec.—6-9-19—H. P. Co.—1000 Bks.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61032

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *816 S. Glover* ST. *1* WARD)2-FULL NAME *Joseph J. Pakulski*(a) RESIDENCE NO. *816 S. Glover* ST. *1* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb, 26, 1874*7 AGE Years *47* Months *11* Days *9* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Poland*  
(State or country)10 NAME OF FATHER *Frank Pakulski*11 BIRTHPLACE OF FATHER (city or town) *Poland*  
(State or country)12 MAIDEN NAME OF MOTHER *Not known*13 BIRTHPLACE OF MOTHER (city or town) *Poland*  
(State or country)14 Informant *Mary Pakulski*  
(Address) *816 S. Glover St*15 Filed *FEB 7 - 1922* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 4* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *Nov. 30*, 19 *21*, to *Feb 4*, 19 *22*.that I last saw him alive on *Feb 1*, 19 *22*.and that death occurred, on the date stated above, at *6:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Pulmonary tuberculosis*(duration) — yrs. *3* mos. — ds.CONTRIBUTORY *Laryngeal tuberculosis*  
(Secondary)(duration) — yrs. *1* mos. — ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date of —Was there an autopsy? *no*What test confirmed diagnosis? *Laboratory*(Signed) *Edward J. Novak*, M. D.19 (Address) *821 N. Patterson Park av*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*St. Stanislaus Cemetery* *Feb. 8* 19 *22*

20 UNDERTAKER ADDRESS

*Stephen J. Pakulski*

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.



N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state  
cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPA-  
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D 61033 HEALTH DEPARTMENT—CITY OF BALTIMORE 61033

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Visitation Cemetery, Park Ave 11* WARD)

2-FULL NAME *Margaret L. Jones*

(a) RESIDENCE No. *Visitation Cemetery, Park Ave + Centre St.* ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *87* yrs. *11* mos. *22* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb 16 1834*

7 AGE Years *87* Months *11* Days *22* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Maryland*

10 NAME OF FATHER *Josua Jones*

11 BIRTHPLACE OF FATHER (city or town) *Unknown* (State or country)

12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town) *Unknown* (State or country)

14 Informant *Per Mother M. Cecylia Looman* (Address) *Visitation Cemetery, Park Ave + Centre St.*

15 File *FEB 7 - 1922* Registrar *GLS*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 6 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Feb 1*, 19*22*, to *Feb 6*, 19*22*,

that I last saw him alive on *Feb 5*, 19*22*,

and that death occurred, on the date stated above, at *11 A.* m.

The CAUSE OF DEATH\* was as follows:

*General Bronchitis*  
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *old age*  
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Lab. ex. Chel*  
(Signed) *Charles O. Brown*, M. D.

*77*, 19*22* (Address) *56 Bond St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Cathedral Cem*

DATE OF BURIAL *Feb 8 1922*

20 UNDERTAKER *Wm J. Hartwell*

ADDRESS *222 W. Baltimore St.*

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS STATEMENT SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

Spec.—1-10-21—M&T—1500 Bks.

D 61034

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 N. Arlington Ave. 18 WARD)

2. FULL NAME George Washington Bennett

(a) RESIDENCE NO. 510 N. Arlington Ave. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 11 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Bennett

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1854

7 AGE Years 67 Months 11 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor & Builder

(b) General nature of industry, business, or establishment in which employed (or employer) D/O

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER Rufus Bennett

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Louisa Waters

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant E. Erdman (Address) 2917 Edgemoor Ave.

15 Filed FEB 7 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/3 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1921, to 2/3, 1922, that I last saw him alive on 2/3, 1922, and that death occurred, on the date stated above, at 9:50 P.M.

The CAUSE OF DEATH\* was as follows:

atherosclerosis of LIVER

(duration) — yrs. 18 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. J. McKenna, M. D.

, 19 (Address) 804 Cathedral St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Landon Park Cemetery Feb 7 1922

20 UNDERTAKER

ADDRESS

John O. Mitchell 1201 N. Fagetta

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS STATEMENT SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

Spec.—1-10-21—M&T—1500 Bks.

D 61035 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Luttrell 300* ST. *11* WARD)

2-FULL NAME *Courtland De Lancy Evans*

(a) RESIDENCE NO. *Luttrell Apartments* ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *57* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Clara V. Evans*

6 DATE OF BIRTH (month, day, and year) *April 17/1862*

7 AGE Years *59* Months *9* Days *18* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Banker*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *New York* (State or country) *New York*

10 NAME OF FATHER *John A. Evans*

11 BIRTHPLACE OF FATHER (city or town) *Phila* (State or country) *Pa*

12 MAIDEN NAME OF MOTHER *Maria A. Evans*

13 BIRTHPLACE OF MOTHER (city or town) *N.Y.* (State or country)

14 Informant *Townsend Smith* (Address) *230 Eager St*

15 Filed *FEB 7-1922* Registrar *John O. Mitchell*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 5 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Nov* 1921, to *Feb 5* 1922,

that I last saw *him* alive on *Jan 30* 1922, and that death occurred, on the date stated above, at *6:30 P* m.

The CAUSE OF DEATH\* was as follows:

*Angina pectoris*  
*(Recurrent attack since Oct 21)*  
(duration) yrs. mos. ds.

CONTRIBUTORY *arterio sclerosis*  
(Secondary) *stroke over same spot*  
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Special examination*  
(Signed) *W. H. Leach* M. D.

(Address) *1008 Cathebra*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Portsmouth New Hamp.* *Feb 9 1922*

20 UNDERTAKER ADDRESS

*John O. Mitchell 1201 W. Fayette*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(Janka)  
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61036

CERTIFICATE OF DEATH.

90 D 61036

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 728 Bond. ST. 3 WARD)

2-FULL NAME

(Residence in Baltimore: No. 728 Bond. ST. yrs. 40 mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH.

Nov 20 1863 (Month) (Day) (Year)

7-AGE.

38 yrs. 2 mos. 15 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Labor (b) General nature of industry, business, or establishment in which employed (or employer). B. O. Rail.

9-BIRTHPLACE.

(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Mrs. Jadwiga Janka (Informant) 728 Bond (Address)

15-

Filed 1922 101. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Dec 4 1912 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

THE CAUSE OF DEATH\* was as follows:

Heart Disease (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) M. D. (Coroner.)

(Address) 191. (Address) 143 N. Bond

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL, OR REMOVAL, DATE OF BURIAL,

Holy Cross German Pic Feb. 8 1922

20-UNDERTAKER ADDRESS

John M. Weber 1803 Bank St



D 61037

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 D 61037

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1518 Dundas St. WARD 14)

## 2-FULL NAME

Robert D. Abell

## (a) RESIDENCE. No.

1518 Dundas St.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Caucasian

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Unknown 1877

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

South Carolina

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

## 14

Informant (Address)

Mrs. Theresa Stewart 1336 Dundas St.

## 15

Filed

19

J. W. Abell

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1922

17

I HEREBY CERTIFY, That I attended deceased from

January 16, 1922, to July 5, 1922

that I last saw him alive on July 4, 1922

and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH\* was as follows:

Mitral Regurgitation

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Curdiness

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. H. Bontecave, M.D.

Dr. 19 (Address) 1504 E. Pratt St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Auburn

## DATE OF BURIAL

July 8 1922

## 20 UNDERTAKER

Samuel P. Hecox

## ADDRESS

378 W. Biddle

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCASION. Exact statement of OCCASION. Exact statement of OCCASION.

D 61038

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

49 D 61038

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 Hollins St. 19 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Charles P. Monaghan

## (a) RESIDENCE. No.

1721 Hollins St.

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs.

mos.

22 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Marie Bryan Monaghan

## 6 DATE OF BIRTH (month, day, and year)

Jan 14, 1861

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

61

22

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

U. S. Custom

(c) Name of employer

House

## 9 BIRTHPLACE (city or town) (State or country)

Balto Md

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

## 12 MAIDEN NAME OF MOTHER

Elizabeth McLaughlin

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

## 14

Informant (Address)

Mr. Joseph Monaghan  
Jersey City, N. J.

## 15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 18 1921, to Feb 4 1922

that I last saw him alive on Feb 4 1922,

and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Prostate  
Embolic of Hip.

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary)

Acute dilatation of heart

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical

(Signed)

Edw. V. Colahan, M. D.

2/6, 1922

(Address) 24 N. Fulton Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

New Cathedral Cem.

Feb 8th 1922

## 20 UNDERTAKER

## ADDRESS

J. J. Bowan & Son  
24 N. Fulton Ave.

901 Hollins

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61039

D 61039

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

James Harris

## (a) RESIDENCE. NO.

1022 N. Sticker

ST.

WARD

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced (write the word)

married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofEssie Harris

## 6 DATE OF BIRTH (month, day, and year)

Apr. 8-1884

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.37928

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Virginia

## 10 NAME OF FATHER

Parker Harris11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Virginia

## 12 MAIDEN NAME OF MOTHER

Sarah Harris13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Virginia

## 14

Informant  
(Address)JOHNS HOPKINS HOSPITAL

## 15

Filed

19

1927-1029J. E. Webb

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5-1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 20-1922, 1922, to Feb 5-1922, 1922,that I last saw him alive on Feb 5-1922, 1922,and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH\* was as follows:

Myocardial insufficiency(duration) 5 yrs. 5 mos. — ds.CONTRIBUTORY  
(Secondary)None(duration) — yrs. — mos. — ds.

18 Where was disease contracted

if not at place of death?

HomeDid an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? None(Signed) Francis R. Dickson, M. D.165, 1922 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in death from Violent Cause, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Int. Burial

## DATE OF BURIAL

Feb 7 1922

## 20 UNDERTAKER

Sam. F. Chase & Co.

## ADDRESS

Woodward

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Luetic Infection*



## D 61040 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 N. ... ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 426 V. ... St. 4 yrs. ... mos. ... ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female 4-COLOR OR RACE: Col 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH: Jan 1, 1941 (Month) (Day) (Year)

7-AGE: 81 yrs. 1 mos. 4 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, John Peters

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pauline L. Wheaton

(Address) 2019 ...

15-

FEB 7 - 1922

Filed ... 191 ... Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 5, 1912 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 18 (91) to 20 7 1912

that I saw her alive on Feb 4 1912

and that death occurred, on the date stated above, at 11:30 p. m.

The CAUSE OF DEATH\* was as follows:

Heart ...

...

...

... (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY ... (Secondary)

... (Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

... (Address) ...

...

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel ...

DATE OF BURIAL, Feb 5, 1912

20-UNDERTAKER, Sam'l W. Chase

ADDRESS, ...

N.B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61041

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *712 N Carey* ST., *16* WARD)2-FULL NAME *Mary E Varney*(a) RESIDENCE NO. *712 N Carey*

(Usual place of abode)

ST.,

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *33* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**white**widowed*

5a If married, widowed, or divorced

(or) WIFE of

*Wm. H. Varney*6 DATE OF BIRTH (month, day, and year) *22 September*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*90*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*New York*

10 NAME OF FATHER

*Thomas J. Hoffman*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*New York*

12 MAIDEN NAME OF MOTHER

*Fannie Tuttle*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*New York*

14

Informant (Address)

*William H. Varney 712 N Carey St*

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 4 1922*

I HEREBY CERTIFY, That I attended deceased from

1906 to *Feb 4 1922*that I last saw him alive on *Feb 4 1922*and that death occurred, on the date stated above, at *2 P m.*

The CAUSE OF DEATH\* was as follows:

*Chronic valvular heart disease (all valves involved) about 15 yrs. mos. ds.*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

19 PLACE OF BURIAL, CREMATION OR RE-

*Greenmount*

20 UNDERTAKER

*William Cook*

DATE OF BURIAL

*27 1922*

ADDRESS

*32 E. 7th St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 4 - 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61042

## CERTIFICATE OF DEATH.

D 61042

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1822 E Monument ST.)

WARD)

## 2. FULL NAME

(a) RESIDENCE No. 1822 E Monument ST.

WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel E Jerby

6 DATE OF BIRTH (month, day, and year) Sept 15 1851

7 AGE Years 70 Months 4 Days 11 LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

10 NAME OF FATHER John Clark

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Eleanor

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14

Informant (Address) Dr. J. G. Lusk 1822 E Monument St

15

FEB 7 - 1922

B. Muse 1234 Franklin St

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 3 1922, to Feb. 6 1922,

that I last saw him alive on Feb. 5 1922, and that death occurred, on the date stated above, at 7:22 m.

The CAUSE OF DEATH\* was as follows:

Coronary dilatation (arterio)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray cough

(Signed) Edward Daniel Muse D.

46, 1922 Address) 1037 N. Franklin St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR DE- MOVAL

DATE OF BURIAL

Laudy Park July 16 1922

UNDERTAKER

ADDRESS

William Beck 502 N. 18th

D 61043

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61043

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2636 Mountingdon* ST. *17* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred *56* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, Divorced, (write the word) *Widowed*6 If married, widowed or divorced, (or) WIFE of *Frederick J. Schmoll*6 DATE OF BIRTH (month, day, and year) *Oct 8-1865*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *56*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Virginia*10 NAME OF FATHER *Winifred Lyons*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ireland*12 MAIDEN NAME OF MOTHER *Helena Roman*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Virginia*14 Informant *Frederick J. Schmoll* (Address) *2636 Mountingdon*15 *FEB 7-1922* *ROBERT R. KRAUTER* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/5 1922*17 I HEREBY CERTIFY, That I attended deceased from *Aug. 5, 1921* to *2/5 1922*, that I last saw him alive on *2/4 1922*, and that death occurred, on the date stated above, at *10:00* a.m.

The CAUSE OF DEATH\* was as follows:

*Chronic myocarditis with hypertrophy & interstitial nephritis.*(duration) *2* yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. / ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *No*(Signed) *J. H. M. M. M.*, M. D.*2/5, 1922* (Address) *804 Cathedral St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Cathedral City* DATE OF BURIAL *2/8 1922*20 UNDERTAKER *William Cook* ADDRESS *502 E. North Ave.*

N. B.—WRITE PLAINLY WITH CARE. PHYSICIANS should state EXACTLY, PHYSICIANS should state EXACTLY, PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.





D 61045

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1130 61045

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital* ST. *3* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Baby Kovner*

## (a) RESIDENCE NO.

*109 S. Bond*

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Jan 26 1922*

7 AGE

Years

Months

Days

11/LESS than 1 day, hrs. or min.

*13*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balti Md.*

10 NAME OF FATHER

*Solomon Koven*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Russia*

12 MAIDEN NAME OF MOTHER

*Jennie Margolis*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Russia*

14

Informant (Address)

*Solomon Koven 109 S Bond St*

15

Filed

*FEB 7 1922**J. M. Koven*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb 7 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 6*, 1922, to *Feb 7*, 1922,that I last saw him alive on *Feb 7*, 1922,and that death occurred, on the date stated above, at *4 A* m.

The CAUSE OF DEATH\* was as follows:

*Marasmus*(duration) *1* yrs. *13* mos. *13* ds.

CONTRIBUTORY (Secondary)

*Dysentery*(duration) *1* yrs. *12* mos. *12* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Louis J. Sachs*, M. D.(Address) *The Hebrew Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Hebrew Mt. Carmel**Feb 1 1922**Map Koven**Balti*

tion should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61046

## CERTIFICATE OF DEATH.

90 D 61046

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

305 West Dolphin

ST. 11

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Virginia Bolton

## (a) RESIDENCE. No.

305 West Dolphin

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 89 yrs. 9 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 9<sup>th</sup> 1832

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

89

9

28

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Hugh W. Bolton

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Co Maryland

12 MAIDEN NAME OF MOTHER

Banksen

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Miss Elvira Bolton 305 Dolphin St.

15

FEB 7 - 1922

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 6 1922

17

I HEREBY CERTIFY, That I attended deceased from

January 18, 1922, to February 6, 1922.

that I last saw her alive on February 5<sup>th</sup>, 1922.

and that death occurred, on the date stated above, at 8:50 a.m.

The CAUSE OF DEATH\* was as follows:

Myocarditis

(duration) 30 days yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Fasting rapid pulse

(Signed) Charles O. Moran, M. D.

1912 (Address) 5 E. Read St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Greenmount Cem

2-8-1922

20 UNDERTAKER

Henry W. Jenkins &amp; Sons 10 McCulloh

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PUBLIC DOCUMENT. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

✓  
MORE  
90 D 61047

**D-67047**  
**1-PLACE OF DEATH**

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred      yrs.      mos.      ds.      How long in U. S., if of foreign birth?      yrs.      mos.      ds.

## MEDICAL CERTIFICATE OF DEATH

Male	White	or Divorced (write the name of the person with whom you are living)
------	-------	---

C Nelson

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
34		10	1	

(a) Trade, profession or particular kind of work *Retired Investment*

(b) General nature of industry, business, or establishment in which employed (or employer) *Bankees*

(c) Name of employer

9 BIRTHPLACE (city or town), *Washington*  
(State or country)

10 NAME OF FATHER *C. R. Nelson*

II BIRTHPLACE OF FATHER (city or town)  
(State or country) *Pa*

12 MAIDEN NAME OF MOTHER *Mary G. Massey*

13 BIRTHPLACE OF MOTHER (city or town) Washington  
(State or country) D.C.

14 Informant W. L. C. Nelson  
(Address) 112 N. Charles St.

15 FEB 7 - 1929 ROBERT R. KRAUTER,

Registrar  
Burial Permit Clerk

16 DATE OF DEATH (month, day, and year) Feb 6 1921

17

I HEREBY CERTIFY, That I attended deceased from  
2/3, 1922, to 2/6, 1922

that I last saw him alive on 2/6 1922

and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH\* was as follows:

Myocardial insufficiency

(duration) 2 yrs. 1 mos. 1 da

CONTRIBUTORY (Secondary) *Subsistence of dam*

(duration)      yrs.      mon.      3      da

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? ☒ Date of \_\_\_\_\_

Was there an autopsy? no

What test confirmed diagnosis? *Physical Examination*

(Signed) Robert H. Smith, M. D.

4/7, 1922 (Address) 1009 Cathedral

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
--	----------------

Of course, however, on Feb. 8.

20	UNDERTAKEN	ADDRESS
----	------------	---------

James W. Jenkins & Son 100



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61048  
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)CITY OF BALTIMORE: (No. *1401 William* ST.: *24* WARD)2-FULL NAME *James E. Harding*(a) RESIDENCE. No. *1401 William* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*5 Single, Married, Widowed,  
or Divorced (write the word)*Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Ellen Harding*6 DATE OF BIRTH (month, day, and year) *Jan 26/1885*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*87*

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Unemployed*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore Md*10 NAME OF FATHER *Not Known*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)12 MAIDEN NAME OF MOTHER *Not Known*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)*James E. Harding  
1401 William St*

15

FEB 7 - 1922

ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 4* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

*1/10*, 19 *22*, to *Feb 4*, 19 *22*that I last saw him alive on *Feb 4*, 19 *22*and that death occurred, on the date stated above, at *6 P.* m.

The CAUSE OF DEATH\* was as follows:

*arterio sclerosis*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date of *No*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

*C. M. D.*

M. D.

1922 (Address) *1278 William St*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Cathedral Cem Co**2/7/22*

20 UNDERTAKER

ADDRESS

*John J. Baker & Sons**1318 Light St.*

mation should be carefully supplied. AGE should be stated EXACTLY. PREVIOUS MARRIAGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61049

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 14257, Charles

2-FULL NAME Lewis A. Attenbarn

(Residence in Baltimore: No. San Jose Cal.)

ST. 31 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH. Unknown, 1

7-AGE. about 40

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant). (Address).

15- Filed FEB 7 - 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb Jan 31, 1922

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry. thereon and from the evidence obtained by said Inquest, autopsy or inquiry. and that said deceased came to death on the day stated above. The CAUSE OF DEATH\* was as follows: Pulmonary tuberculosis

CONTRIBUTORY (Secondary).

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death. In the State. Where was disease contracted, if not at place of death? Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. St. Vincent's Cemetery DATE OF BURIAL, Feb 7th, 1922

20-UNDERTAKER. B. J. Fanning, Jan 1938 E. Lafayette Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61050

## CERTIFICATE OF DEATH.

90

D 61050

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *213 Overland Ave* ST. *27* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Dr. Edward M. Wise*(a) RESIDENCE. NO. *213 Overland Ave* ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *65* yrs. *7* mos. *27* ds. How long in U. S., if of foreign birth? *65* yrs. *7* mos. *27* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*6a If married, widowed, or divorced HUSBAND of (or) WIFE of *Single*6 DATE OF BIRTH (month, day, and year) *May 9, 1856*7 AGE Years *65* Months *7* Days *27* If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Doctor*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.* (State or country)10 NAME OF FATHER *Edw. M. Wise*11 BIRTHPLACE OF FATHER (city or town) *Maryland* (State or country)12 MAIDEN NAME OF MOTHER *Harriett Hays*13 BIRTHPLACE OF MOTHER (city or town) *Maryland* (State or country)14 Informant *Laura Kaiser* (Address) *213 Overland Ave*

15 FEB 7 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 5, 1922*17 I HEREBY CERTIFY, That I attended deceased from *Feb 5*, 1922, to *Feb 5*, 1922,that I last saw him *alive* on *Feb. 5*, 1922, and that death occurred, on the date stated above, at *5:30* p. m.

The CAUSE OF DEATH\* was as follows:

*Cardiac Insufficiency ?*  
*Found dead.*

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

## CONTRIBUTORY (Secondary)

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date of \_\_\_\_Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Geo. S. Zimmerman*, M. D.19 (Address) *2858 94th St. N.D.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Greenmount Cemetery* DATE OF BURIAL *Feb. 8, 1922*

20 UNDERTAKER

*Mrs. John H. Seigler* ADDRESS *South Fayette St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D 61051  
1-PLACE OF DEATHCITY OF BALTIMORE: (No. 5000 C'Donnell ST., 76 WARD)

2-FULL NAME

Charles A. Adams

(a) RESIDENCE NO.

5000 C'Donnell ST., 76 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 25 - 1865

7 AGE

56

Years

Months

Days

If LESS than  
t day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Standard Oil

(c) Name of employer

Barto. Co.

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Michael Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Margaret Schorr

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md.

14

Informant (Address)

Catherine Guinness  
5000 C'Donnell St

15

FEB 7 - 1922

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 192217 I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1922, to Feb. 6, 1922, that I last saw him alive on Feb. 5, 1922, and that death occurred, on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia(duration) yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of noWas there an autopsy? no

What test confirmed diagnosis?

(Signed) C. A. Reischneider M. D.2-6, 1922 (Address) 2939 Eastern Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Sacred Heart

DATE OF BURIAL

Feb. 9 1922

ADDRESS

4031 N. 1st St

20 UNDERTAKER

Lilly and Ziehl

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61052

## CERTIFICATE OF DEATH.

D 61052

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *510 S. Belmord av.* ST.)

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S.. If of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White.*

5 Single, Married, Widowed, or Divorced (write the word)

*Married.*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Agnus Vogel.*6 DATE OF BIRTH (month, day, and year) *Oct. 1855*

7 AGE

*66*

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Mill worker.*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Morgan Co.*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*

10 NAME OF FATHER

*John Vogel.*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany.*

12 MAIDEN NAME OF MOTHER

*unknown.*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany.*

14

Informant (Address)

*James J. Vogel. 370 S. Belmord av.*

15

FEB 7-1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb. 5 1922*

17

I HEREBY CERTIFY, that I attended deceased from *Jan 9*, 19*22*, to *Feb 5*, 19*22*, that I last saw him alive on *Feb 8*, 19*22*.and that death occurred, on the date stated above, at *11.30 P.* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Nephritis about 1* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted? ☒ If not at place of death?Did an operation precede death? *No* Date of ☒Was there an autopsy? *No*What test confirmed diagnosis? *Chemical*

(Signed)

*Leo Heller*

M. D.

27, 1922 Address)

*1937 Gough St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Sacred Heart Cem.*

DATE OF BURIAL

*Feb. 8 1922*

20 UNDERTAKER

*Lilly and Zeiler*

ADDRESS

*4038 N. 4th St.*

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61053

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3608 Foster Ave* ST. *16* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Mildred M. Sanders.*(a) RESIDENCE. NO. *3608 Foster Ave* ST. *16* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *4* yrs. *3* mos. *3* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Sept. 19-1907*

7 AGE

*14*

Years

Months

*4*

Days

*18*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Home.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balto. Co. Md.*

10 NAME OF FATHER

*Louis F. Sanders.*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*New York.*

12 MAIDEN NAME OF MOTHER

*Minnie Jeffries*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balto. Md.*

14

Informant (Address)

*Louis F. Sanders. 3608 Foster Ave.*

15

FEB 7-1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 6* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *1* 19 *22*, to *2* 6 19 *22*.that I last saw her alive on *2* 1 19 *22*.and that death occurred, on the date stated above, at *6.45* a. m.

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*

CONTRIBUTORY (Secondary)

*Chronic Nephritis*

18 Where was disease contracted if not at place of death?

*unknown*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Observation*(Signed) *Harace B. Litchow, M. D.*19 (Address) *315 S. Highland Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Baltimore Ave.*

DATE OF BURIAL

*Feb. 9<sup>th</sup> 1922*

20 UNDERTAKER

*Lilly and Ziehl*

ADDRESS

*403 S. Wolfe*

mation should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 61054

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61054

## CERTIFICATE OF DEATH.

74-001  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1907 E. Chase ST.,

WARD)

## 2-FULL NAME

Annie B. Cooper

(a) RESIDENCE No. 1907 E. Chase

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

George P. Cooper

6 DATE OF BIRTH (month, day, and year)

Sept. 5, 1861

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

60

3

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Henry Von Newkirk

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Lena Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Geo. P. Cooper 1907 E. Chase St.

15

Robert P. Harrison,

19

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 14, 1922, to Feb 5, 1922

that I last saw her alive on Feb 5, 19

and that death occurred, on the date stated above, at 6:10 P. m.

The CAUSE OF DEATH\* was as follows:

Exhaustion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pt Hemiplegia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. J. Pittman, M. D.

19 (Address) 1038 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Baltimore

20 UNDERTAKER

Jirkler &amp; Jirkler E. J. J.

DATE OF BURIAL

Feb 8, 1922

ADDRESS

Eager

tion should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

B7-1922

D 61055

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61055

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 471 Paul ST.: 11 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *John A. Tephendurman*

(Residence in Baltimore: No. 838 St Paul St St.; .....yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, <i>Male</i>	4-COLOR OR RACE, <i>White</i>	5-SINGLE, MARRIED, <i>Single</i> WIDOWED, OR DIVORCED, (Write the word.)
-----------------------	----------------------------------	--

6-DATE OF BIRTH, July 16, 1836  
(Month) (Day) (Year)

7-AGE, 85 yrs. 6 mos. 21 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work.....None  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,  
(State or Country), D. C.

10-NAME OF FATHER. *G. H. Linn*

11-BIRTHPLACE  
OF FATHER  
(State or Country), *Germany*

12-MAIDEN NAME OF MOTHER *F G 16 8 00*

13-BIRTHPLACE  
OF MOTHER  
(State or Country), *Massachusetts*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....Mo T. L. Mar.....

(Address) 808 Hume St

18- Robert P. Harrison,

Filed....., 191.....

1000

**MEDICAL CERTIFICATE OF DEATH.**

16-DATE OF DEATH, February 27, 1912.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from  
Feb 1919, to Feb 1922,  
that I saw him alive on Feb 1922,  
and that death occurred, on the date stated above, at 5:11 p.m.

The CAUSE OF DEATH\* was as follows:

*Alnus arbutus* -  
*Alnus incana* -  
(Barbation) 3 yrs. - - - - -

CONTRIBUTORY.....General Insurance.....  
(Secondary).....

..... (Duration) ..... yrs. .... mos. .... da.  
(Signed) *W. J. Mayo* ..... M. D.  
*Feb. 7, 1912* (Address) *Baltimore -*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death	Yrs.	Mos.	ds.	In the State	Yrs.	Mos.	ds.
----------------------	------	------	-----	-----------------	------	------	-----

Where was disease contracted,  
if not at place of death?

Former or usual residence .....

<u>18-PLACE OF BURIAL OR REMOVAL.</u>	<u>DATE OF BURIAL.</u>
---------------------------------------	------------------------

Greenmount Tenn Feb. 8. 1822

[illegible]

Wm. A. Jenkins & Co. Chicago



D 61056 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61056

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Franklin Square Hospital* REGISTERED NO. C  
 CITY OF BALTIMORE: (No. *Baltimore Md.* ST.; WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
 2-FULL NAME *Mrs Nellie Harris*  
 (Residence in Baltimore: No. *121 N Pine St.* St.; *Life* yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, *Married*  
 6-DATE OF BIRTH, *March 3, 1879*  
 (Month) (Day) (Year)  
 7-AGE, *42* yrs. mos. da. IF LESS than 1 day, hrs. or min.  
 8-OCCUPATION:  
 (a) Trade, profession, or particular kind of work. *037*  
 (b) General nature of industry, business, or establishment in which employed (or employer). *House duties*

9-BIRTHPLACE,  
 (State or Country), *Baltimore*

10-NAME OF FATHER, *Jessy H Murray*  
 11-BIRTHPLACE OF FATHER (State or Country), *Maryland*  
 12-MAIDEN NAME OF MOTHER, *Amelia Tracy*  
 13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Simon Harris*  
 (Address) *121 N Pine St.*

15-

Filed, *7-1922* *Robert P. Harrison,* Registrar.  
*Burial Permit Clerk*

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *February 7, 1922*  
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Jan 22, 1921* to *Jan 7, 1922*, that I saw her alive on *Jan 6, 1922*, and that death occurred, on the date stated above, at *12* A.m.

The CAUSE OF DEATH\* was as follows:

*Cholecystitis (acute)*  
*over*  
 (Duration) *3* yrs. mos. da.

CONTRIBUTORY (Secondary) *abdominal pain*

(Duration) *15* yrs. mos. da.  
 (Signed) *Nesta S. Parr* M. D.  
*2/7/22*, 1922 (Address) *Frank St. 160 Pa.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *2* yrs. mos. + da. In the State *2* yrs. mos. da.

Where was disease contracted, if not at place of death? *Home*

Former or usual residence *121 N. Pine St.*

19-PLACE OF BURIAL OR REMOVAL, *Mt Olivet* DATE OF BURIAL, *Feb. 9, 1922*

20-UNDERTAKER, *J. Ahrens & Co* ADDRESS, *160 Madison Ave*

Every item of information should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FEB 7-1922

D 61057

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61057

## CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *314 Reeburg* St. *11* WARD)FULL NAME *Wm. Gibson Kramer*(Residence in Baltimore: No. *319 E. 25th St.* St.: yrs. mos. ds.)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

Robert B. Harrison,

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry,

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Organic heart disease.*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

(Coroner)

Feb. 4, 1922 (Address) *203 E. Lombard St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

EB7-1922 Burial Permit Clerk.

D 61058

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61058

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 Astor)

ST.: WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mary Ruth Widman

## (a) RESIDENCE. No.

1211 Astor

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos.

ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Widowed

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John Widman

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

24

2

19

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Germany

## 10 NAME OF FATHER

John Haas

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Helen

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

## 14

Informant (Address)

Mrs. C. F. French 1211 Astor

## 15

Filed

H. H. HARRISON,

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb 6 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb 3, 1922, to Feb 6, 1922

that I last saw him alive on Feb 5, 1922.

and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH\* was as follows:

Sinteria

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Edwin G. G. G. M. D.

2/7, 1922 (Address) 511 East St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Green Park

Feb 8 1922

## 20 UNDERTAKER

## ADDRESS

John J. J. J. 1200 N. Lombard

Information should be carefully supplied. Age should be stated in years, months, and days. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

B 7-1922 Social Permit Clerk

D 61059 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61059

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3619 Roland Ave. 13 WARD)

## 2-FULL NAME

Margaret M. Amy

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

3619 Roland Ave ST.

## WARD

(Usual place of abode) Length of residence in city or town where death occurred 14 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? 14 yrs. 4 mos. 4 ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow6a If married, widowed, or divorced HUSBAND of (or) WIFE of Rev. Calvin Amy6 DATE OF BIRTH (month, day, and year) 27 9 18887 AGE 33 Years Months Days If LESS than 1 day, .... hrs or .... min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ind10 NAME OF FATHER Frederick Hamburg11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Dauter13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dauter

PARENTS

14 Informant (Address) Margaret L. Crouse  
3619 Roland Ave

15

Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-5 192217 I HEREBY CERTIFY, That I attended deceased from Feb 3 1922 to Feb 5 1922that I last saw her alive on Feb 3 1922and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH\* was as follows:

SenilityCONTRIBUTORY (Secondary) Pulmonary Disease (duration) yrs. mos. ds. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -Was there an autopsy? NoWhat test confirmed diagnosis? Physiologic (Signed) Robt. Norman M. D.2.7.1922 (Address) 8347 Chestnut Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Little Co. Home

DATE OF BURIAL

20 UNDERTAKER Foster Funeral

ADDRESS

Wing 502 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

87

1922

Permit Clerk



D 61060

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, Divorced (write the word)

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

Filed

HARRISON, Registrar

Burial Permit

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 14, 1922, to Feb. 7, 1922.

that I last saw her alive on Feb. 6, 1922.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Chronic diffuse  
myelitis  
Unknown (duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine exam.

(Signed) W. H. Smith, M. D.

2/7, 1922 (Address) 3429 Chestnut St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

BURYAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

Rockville Ind  
William Coops9/10 1922  
502 E NorthExact statement of PA-  
tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S  
CAUSE OF DEATH in plain terms, so that it may be properly classified.  
TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61061

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2011 Homewood Ave. WARD 9)2-FULL NAME Henry Brunsden(a) RESIDENCE No. 2011 Homewood Ave. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vera M. Brunsden6 DATE OF BIRTH (month, day, and year) Unknown7 AGE Years 54 Months — Days — If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk(b) General nature of industry, business, or establishment in which employed (or employer) Country Club

(c) Name of employer

9 BIRTHPLACE (city or town) England (State or country)10 NAME OF FATHER Henry M. Brunsden11 BIRTHPLACE OF FATHER (city or town) England (State or country)12 MAIDEN NAME OF MOTHER Do not know13 BIRTHPLACE OF MOTHER (city or town) England (State or country)14 Informant Vera M. Brunsden (Address) 722 N. Homewood Ave.15 Robert F. Harrlegh, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 192217 I HEREBY CERTIFY, That I attended deceased from Dec 1921, to Feb 1922, that I last saw him alive on Sunday Feb 5, 1922, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH\* was as follows:

aneurysm of the ascending  
transverse arch of the aorta  
(Ruptured)  
(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? By X-Ray & Fluoroscope(Signed) Louis H. Friedman, M. D.19 (Address) 722 North Homewood Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Wm. Cook & Son 602 E. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

7-1922

Burial Permit Clerk

D 61062 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61062

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4015 Park Heights ST., 15 WARD)

## 2-FULL NAME

George P. Ways

## (a) RESIDENCE NO.

4015 Park HeightsST., 15 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

32 yrs. 0 mos. 27 ds.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Ways6 DATE OF BIRTH (month, day, and year) Jan 9/18907 AGE Years 32 Months 0 Days 27 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Solicitor at Law

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Merchants & Miners

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

## 10 NAME OF FATHER

Robert P. Ways

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balti. Md.

## 12 MAIDEN NAME OF MOTHER

Sarah M. McCord

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Sta. Md.

## 14

Informant (Address)

Mrs. Sarah M. Ways  
4015 Park Heights

## 15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6 192217 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1922, to Feb 6, 1922.that I last saw him alive on Feb 6, 1922.and that death occurred, on the date stated above, at 5:15 m.

The CAUSE OF DEATH\* was as follows:

Lobular Pneumonia(duration) yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary)

Chronic Nephritis(duration) yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death?

at homeDid an operation precede death? no Date of xWas there an autopsy? noWhat test confirmed diagnosis? Physical(Signed) E. Huber Wheeler, M. D.(Address) 2129 W. 11th

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Greenmount Cem

DATE OF BURIAL

19

20 UNDERTAKER

Wm. H. H. H. H. H.

ADDRESS

1000 Pa.

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

B7-1922

Information should be carefully supplied. Exact statement of OCCUR-  
 CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

15077 61063

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61063

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 70 HOPKINS H. SPITAL ST.: 70 WARD)

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## 2-FULL NAME

Edwin Sorenson

## (a) RESIDENCE. NO.

2242 McCleary

ST.: 20th

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

2 yrs. 6 mos. 10 ds.

How long in U. S., if of foreign birth?

yrs. 6 mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

male

## 4 COLOR OR RACE

white

5 Single, Married, Widowed,  
or Divorced (write the word)

single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Aug 24<sup>th</sup> 1918

## 7 AGE

Years 3

Months 5

Days —

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

child

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Wilmington

## 10 NAME OF FATHER

William Sorenson

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Eva Sorenson

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

## 14

Informant  
(Address)

HOPKINS H. SPITAL

## 15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb. 6<sup>th</sup> 1922

## 17

I HEREBY CERTIFY, That I attended deceased from  
Sept 20, 1921, to Feb 6, 1922

that I last saw him alive on Feb 6, 1922

and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH\* was as follows:

Brain tumor - Glioma  
frontal lobe

(duration) yrs. 6 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

Unknown

if not at place of death?

Did an operation precede death?

Yes

Date of Sept 22, 1921

Was there an autopsy?

Yes

What test confirmed diagnosis?

(Signed) Edwin C. Johnson, M. D.

, 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Western Cemetery Feb 8/22

## 20 UNDERTAKER

## ADDRESS

F. B. Huppert 2236 E. 1st Ave

87-1922



ation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -1-10-21- M&T- 1500 Bka.

(Reinhardt)  
D 61064 HEALTH DEPARTMENT-CITY OF BALTIMORE 3 D 61064

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Church Home Infirmary*  
CITY OF BALTIMORE: (No. *120-6 N. Broadway* ST. WARD)  
2-FULL NAME *Mrs. Helena B. Reinhardt*  
(a) RESIDENCE NO. *1510 N. Wolfe* ST. WARD  
(Usual place of abode)  
Length of residence in city or town where death occurred *4* yrs. *4* mos. *4* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F.* 4 COLOR OR RACE *White* 5 *Single* Married, Widowed, or Divorced (write the word)  
5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Eustace Reinhardt*  
6 DATE OF BIRTH (month, day, and year) *Aug 2-1853*  
7 AGE Years *68* Months *6* Days *4* If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED  
(a) Trade, profession or particular kind of work *None*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) *Richmond* (State or country) *Va*  
10 NAME OF FATHER *Jack Vins*  
11 BIRTHPLACE OF FATHER (city or town) *Va* (State or country)  
12 MAIDEN NAME OF MOTHER *May E. Brown*  
13 BIRTHPLACE OF MOTHER (city or town) *Va* (State or country)

14 Informant *Wm. Bailey* (Address) *1510 N. Wolfe St.*

15 *Robert P. Harrison,* Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 6 1922*  
17 I HEREBY CERTIFY, That I attended deceased from *Feb 3*, 1922, to *Feb 6*, 1922, that I last saw her alive on *Feb 6*, 1922, and that death occurred, on the date stated above, at *7 a. m.* The CAUSE OF DEATH\* was as follows:

*General Peritonitis*

(duration) yrs. mos. *1* ds.  
CONTRIBUTORY *Cholelithiasis & Cholecystitis* (Secondary) (duration) *10* yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *Feb. 4-1922*

Was there an autopsy? *Yes*

What test confirmed diagnosis? *Operation + Autopsy*

(Signed) *Richard S. Coblentz* M. D.

19 (Address) *Church Home Infirmary*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Baltimore Cemetery* DATE OF BURIAL *Feb 6 1922*

20 UNDERTAKER *W. H. Moore* ADDRESS *1727 N. Wolfe St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61065

## CERTIFICATE OF DEATH.

49 D 61065

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Cor Forrest & Chase St. 10* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *St. Frances Convent & Chase* St.; *54* yrs.,  mos.  ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE. *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single* (Write the word.)6-DATE OF BIRTH, *11* (Month) *10* (Day) *1849* (Year)7-AGE, *72* yrs. *2* mos. *35* ds. If LESS than 1 day, ....hrs. or....min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Housewife* (b) General nature of industry, business, or establishment in which employed (or employer). *000*9-BIRTHPLACE, (State or Country), *Kentucky*10-NAME OF FATHER, *John Lee*11-BIRTHPLACE OF FATHER (State or Country), *Kentucky*12-MAIDEN NAME OF MOTHER *Agnes Boone*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mother Margaret Mary*(Address) *St. Frances Convent*

FEB 8-1922 ROBERT R. KRAUTER,

Filed..... 191..... Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb.* (Month) *4* (Day) *1922* (Year)17- I HEREBY CERTIFY, That I attended deceased from *For about 12 hrs.* to *Feb. 5.* 1922, that I saw her alive on *Feb. 4* 1922, and that death occurred, on the date stated above, at *8 p.* m. The CAUSE OF DEATH\* was as follows:*Glandular Sarcoma* (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)..... (Duration).....yrs.....mos.....ds.

(Signed) *Mary F. Vaegleiss* M. D. *2.6* 1922 (Address) *1028 Valley St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Cathedral Cemetery* DATE OF BURIAL, *Feb. 8* 192220-UNDERTAKER *John B. Pyle* ADDRESS *1028 Valley St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Enter in plain terms. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61066

## CERTIFICATE OF DEATH.

101-001 61066  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 Orchard ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Wallace (Talbot)(Residence in Baltimore: No. 529 Orchard St. 25 yrs. 0 mos. 0 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married6-DATE OF BIRTH. November, 1869  
(Month) (Day) (Year)7-AGE. 53 yrs. 0 mos. 0 ds. IF LESS than 1 day, 0 hrs. or 0 min.8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. Cook  
(b) General nature of industry, business, or establishment in which employed (or employer). 0219-BIRTHPLACE. (State or Country). Charleston S.C.10-NAME OF FATHER. William Wallace Talbot11-BIRTHPLACE OF FATHER (State or Country). S.C.12-MAIDEN NAME OF MOTHER. Louisa Talbot13-BIRTHPLACE OF MOTHER (State or Country). S.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Wallace Talbot(Address) 529 Orchard St.15- FEB 8-1922 ROBERT R. KRAUTER,Filed 1922 Burial Permit 2578

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. July, 5<sup>th</sup>, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Jan 30, 1922, to July 5, 1922, that I saw him alive on July 4, 1922, and that death occurred, on the date stated above, at 3:54 p. m. The CAUSE OF DEATH\* was as follows:  
Lobes pneumonia(Duration) 0 yrs. 0 mos. 12 ds.CONTRIBUTORY (Secondary) None known(Duration) 0 yrs. 0 mos. 0 ds.(Signed) Chas. H. Kellum M.D.  
July 7, 1922 (Address) 222 W. Monument St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Franklin DATE OF BURIAL. Feb 8, 192220-UNDERTAKER. James H. Hensley ADDRESS. 1225 N. Middle St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. State statement on back of certificate. Important. See instructions on back of certificate.

*Holbow 2303 N. Calvert St.*  
HEALTH DEPARTMENT—CITY OF BALTIMORE

61067

## CERTIFICATE OF DEATH.

44 D 61067

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3928 Clover Hill Road* ST. *17* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Annie E. Solbow*

## (a) RESIDENCE NO.

*3928 Clover Hill Road* ST.

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *45* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? *0* yrs. *0* mos. *0* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Ruben H. Solbow*6 DATE OF BIRTH (month, day, and year) *March 4, 1846*7 AGE Years *75* Months *0* Days *1* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Philadelphia Pa.*

## 10 NAME OF FATHER

*Colman Taylor*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Va.*

## 12 MAIDEN NAME OF MOTHER

*Julia Brown*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Phila. Pa.*

## 14

Informant  
(Address)*Wm. H. E. Chan*

## 15

FEB 8 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 6, 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan 15, 1922* to *Feb 5, 1922*.  
that I last saw her alive on *Feb 5, 1922*  
and that death occurred, on the date stated above, at *145* A. M.

The CAUSE OF DEATH\* was as follows:

*Cardiac Dilatation from  
Chronic Arteriosclerosis  
of the heart.*(duration) *6* yrs. *0* mos. *0* ds.CONTRIBUTORY  
(Secondary)*Valvular heart disease*(duration) *8* yrs. *0* mos. *0* ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *W. H. E. Chan* M. D.2/6, 1922 (Address) *2303 N. Calvert St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Mount Carmel Cem.*

DATE OF BURIAL

*Feb. 9, 1922*

20 UNDERTAKER

*H. Sander Sons*

ADDRESS

*1700 Fleet St.*

ation should be carefully supplied. AGE should be stated in years, months, and days. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

1256



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61068

D 61068

## CERTIFICATE OF DEATH.

31

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 31 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Columbus Marshall(a) RESIDENCE. No. 632 E. Clement st.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofUnknown6 DATE OF BIRTH (month, day, and year) 1855

7 AGE

Years

Months

Days

If LESS than  
1 day, ... hrs.  
or min.67

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Watchman062

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

Unknown9 BIRTHPLACE (city or town)  
(State or country)Maryland10 NAME OF FATHER John Marshall

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland12 MAIDEN NAME OF MOTHER Sally Spedden

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant  
(Address)Hospital RecordsM. T. H.

15

Filed

FEB 8-1922Burial PermitCHAS.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5, 1922

17

I HEREBY CERTIFY, That I attended deceased from  
Dec. 14, 1921 to Feb. 5, 1922that I last saw him alive on Feb. 4, 1922and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(duration) 2 yrs. mos. ds.CONTRIBUTORY Diabetes Mellitus  
(Secondary)(duration) 7 yrs. mos. ds.18 Where was disease contracted  
If not at place of death? UnknownDid an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed)

1-5-22 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London ParkFeb. 8 1922

20 UNDERTAKER

ADDRESS

H. Sander Sons1710 Red H

mation should be carefully supplied. Ave. should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61069

## CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE

ST. 9 WARD

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

3

ds.

How long in U. S., if of foreign birth?

If nonresident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

C. d.

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

No.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Works

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

New London Md

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Mary Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Mary Taylor  
New London Md

15

Filed

6-11-19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 7 1922

17 I HEREBY CERTIFY, that I attended deceased from

February 5, 1922, to February 7, 1922,

that I last saw him alive on February 7, 1922,

and that death occurred, on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH\* was as follows:

Intestinal obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Abdominal adhesions

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. C. Manning, M. D.

, 19 (Address) 37 Joplin St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New London Md

Feb 8 1922

20 UNDERTAKER

ADDRESS

Joseph A. Farrell

2812 Dink

mation should be carefully supplied. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61070

## CERTIFICATE OF DEATH.

90 D 61070

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 321 S Poppleton St.;

WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 321 S Poppleton St.;

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Life mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, Widowed (Write the word.)

6-DATE OF BIRTH, July 27, 1859 (Month) (Day) (Year)

7-AGE, 62 yrs. 6 mos. 10 da. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Hw (b) General nature of industry, business, or establishment in which employed (or employer), ooo

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, Jos Husbach

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Morsley

(Address) 321 S Poppleton

15-661-8811 ROBERT R. KRAUTER,

Filed..... 191..... Burial Permit Clerk, Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 6, 1922 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Dec 10, 1921 to Feb 6, 1922, that I saw him alive on Feb 6, 1922, and that death occurred, on the date stated above, at 6:45 p.m.

The CAUSE OF DEATH\* was as follows:

Acute Scurvy (Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)

(Signed) John G. Selverus, M. D. 2-7-22 Address 1120 W. Lewis

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Garden Park Cem.

DATE OF BURIAL, 2/9/22

20-UNDERTAKER, 19th Bkms & Son

ADDRESS, 1120 W. Lewis

CAUSE OF DEATH in plain terms, so that it may be properly classified. Enter statement on back of certificate. Important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 15-3848-1071) INS. HOSPITAL

ST.: 22 WARD)

2-FULL NAME

Audrey Cowgill

(a) RESIDENCE. NO.

600 W. Barrie

ST.,

WARD.

(Usual place of abode)

631

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

not known

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 6-1921

7 AGE

Years

Months

Days

If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.

7 mos.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Thos. Joseph Cowgill

11 BIRTHPLACE OF FATHER (city or town)

Edwards

(State or country)

Demond Co. Md.

12 MAIDEN NAME OF MOTHER

Ethel A. Tapscott

13 BIRTHPLACE OF MOTHER (city or town)

Easton

(State or country)

Md.

14

Informant (Address)

Thos. Joseph Cowgill 631 W. Barrie St.

FEB 8-1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 6-1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 21, 1922, to Feb 6, 1922

that I last saw her alive on Feb 6, 1922

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:

Early hereditary syphilis

CONTRIBUTORY (duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Secondary) (duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No - Date of \_\_\_\_

Was there an autopsy?

What test confirmed diagnosis? Lumbar puncture

(Signed) Horace G. Stewart, M. D.

76, 1922 (Address) Johns Hopkins Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Londond Park

Feb 8 1922

20 UNDERTAKER

ADDRESS

Knell &amp; Son

1729 W. Pratt



N. B.—Every item of information should be carefully supplied. AGE must be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

61072

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

490 61072

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 826 Hampson St. ST. 14

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Clarence Williams

(Residence in Baltimore: No.

826 Hampson St.

St.; yrs., 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH,

Nov. 27, 1882

(Month) (Day) (Year)

7-AGE,

40 yrs. 2 mos. 9 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

General

9-BIRTHPLACE, (State or Country),

Ind.

10-NAME OF FATHER,

Henry Williams

11-BIRTHPLACE OF FATHER (State or Country),

Ind.

12-MAIDEN NAME OF MOTHER

Doris Khan

13-BIRTHPLACE OF MOTHER (State or Country),

Doris Khan

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. C. Williams

(Address) 826 Hampson St.

15-

Filed

EB 8-1922

ROBERT R. KRAUTER,

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Feb. 5, 1922

(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

opsy or inquiry, find that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Carcinoma of throat

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.

(Coroner)

Feb. 7, 1922 Address 202 E. ...

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

At ...

Feb. 8, 1922

20-UNDERTAKER

ADDRESS

...

58 W. ...

D 61073 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61073

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 21 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Queen(a) RESIDENCE. NO. 1140 Russell St.ST. 21 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced  
HUSBAND of Margaret Queen  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18607 AGE Years 61 Months -- Days -- If LESS than 1 day, hrs. -- or min. --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis,  
(State or country) Maryland10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown  
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)14 Informant Hospital Records  
(Address) Municipal Hospital.15 Filed FEB 8 - 1922 19 ROBERT R. KRAUTER  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7 192217 I HEREBY CERTIFY, That I attended deceased from December 6, 1920, to February 7, 1922  
that I last saw him alive on February 7, 1922,  
and that death occurred, on the date stated above, at 8:00 A.M.  
The CAUSE OF DEATH\* was as follows:Myocardial Insufficiency(duration) 1 yrs. mos. ds.CONTRIBUTORY  
(Secondary)(duration) 1 yrs. mos. ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Aut.  
(Signed) Clyde M. King M. D.2/8/23 Address) Municipal Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. AmbroseJan 9 1922

20 UNDERTAKER

Samuel H. Hensley

ADDRESS

5710  
Biddle

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61074

D 61074

1-PLACE OF DEATH

Boy Run Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.: WARD)

2-FULL NAME

Henry Clayton

(a) RESIDENCE. No.

ST.: WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

Black

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

None

6 DATE OF BIRTH (month, day, and year)

1883

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

39.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Boy Run Hospital  
Baltimore, Md.

15

FEB 8-1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 7, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 12, 1922 to Feb. 7, 1922

that I last saw him alive on Feb. 6, 1922

and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH\* was as follows:

General Paralysis (of the limbs)

CONTRIBUTORY (Secondary) Enteric Infection

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. J. Friedman, M. D.

(Address) 217/922 Boy Run Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn

2/10 1922

20 UNDERTAKER

ADDRESS

J. L. Friedman

5750  
Bed St.

Information should be carefully supplied. Age should be stated in years, months, and days. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 61075

## HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 61075

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bayview Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 19

WARD)

2-FULL NAME

Edwin Forest.

(a) RESIDENCE. NO.

116 S. Calhoun

ST.

WARD.

(Usual place of residence)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

1 year

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Agnes Forest.

6 DATE OF BIRTH (month, day, and year)

1871

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

51.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Glass Blower

(b) General nature of industry, business, or establishment in which employed (or employer)

086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Missouri

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Bayview Hospital Baltimore, Md.

15

FEB 8-1922

ROBERT R. KRAUTER, Registrar

Burial Permit

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 5, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 17, 1922, to Feb. 5, 1922

that I last saw him alive on Feb. 5, 1922

and that death occurred, on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH\* was as follows:

General Paralysis of the Brain

CONTRIBUTORY (Secondary)

Lungs Infection

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

2/7/22

19

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Cemetery Feb 8, 1922

20 UNDERTAKER

ADDRESS

Joseph L. S. 1400 North

Information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



D 61076 HEALTH DEPARTMENT—CITY OF BALTIMORE 61076

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 700 Edmondson Ave. ST., 17 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Eva May Guba

## (a) RESIDENCE NO.

700 Edmondson Ave.

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Charles W. Guba

6 DATE OF BIRTH (month, day, and year) Aug. 28<sup>th</sup> 1880

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 41 4 8

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Pennsylvania

10 NAME OF FATHER James P. Mc Cardell

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Pennsylvania

12 MAIDEN NAME OF MOTHER Martha Singleton

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

## 14

Informant Howard Mc Cardell (Address) White Rock, Md.

## 15

Filed

FEB 8 1922

ROBERT R. KRAUTER, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5<sup>th</sup> 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1922, to Feb 5, 1922, that I last saw her alive on Feb 5, 1922, and that death occurred, on the date stated above, at 8 P. m. The CAUSE OF DEATH\* was as follows:

Tetany + cardiac failure

CONTRIBUTORY (Secondary) removal of thyroid (duration) yrs. mos. ds. 5

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of about 5 m

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Feb 6<sup>th</sup> 1922 (Address) 1002 M. K. Wale M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Union, Pa.

## 20 UNDERTAKER

Joseph B. Cook

## DATE OF BURIAL

Feb 9 1922

## ADDRESS

1002 M. K. Wale

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61077

## CERTIFICATE OF DEATH.

44 D 61077

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2517 E. Hoffman ST. 8 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. 2517 E. Hoffman ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos.

ds.

How long in U. S., if of foreign birth? 50 yrs. mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male white widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Matilda J. King

6 DATE OF BIRTH (month, day, and year)

Apr. 28, 1853

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

68

4

9

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Custom Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Elizabeth K. Morgan 2517 E. Hoffman ST.

15

Filed

19

FEB 8-1922

ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 6 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 26, 1922, to Feb. 6, 1922

that I last saw him alive on Feb. 6, 1922

and that death occurred, on the date stated above, at 10:35 p.m.

The CAUSE OF DEATH\* was as follows:

Cancer of Stomach (duration) 6 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 20 Date of

Was there an autopsy? 20

What test confirmed diagnosis?

(Signed)

J. B. Crumbach M. D. 1531 E. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer

2/9/ 1922

20 UNDERTAKER

ADDRESS

Wm Cook, 502 E. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61078

## CERTIFICATE OF DEATH.

44 D 61078

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *744 W. Balto.* ST., *4* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

*Margaret O'Day*

## (a) RESIDENCE NO.

*744 W Balto. St.* ST.,

## WARD

(Usual place of abode)

Length of residence in city or town where death occurred *19* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Female White Single*6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*None*

## 6 DATE OF BIRTH (month, day, and year)

*Unknown 1869*

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.*52*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*At Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

*ood*

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Ireland*

## 10 NAME OF FATHER

*Dout Kuon*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Dout Kuon*

## 12 MAIDEN NAME OF MOTHER

*Dout Kuon*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Dout Kuon*

## 14

Informant

(Address)

*Mrs Victoria Buckhally  
914 Ryan St*

## 15

Filed

FEB 8 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*Feb 7 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*Feb 2 1922, to Feb 8 1922*that I last saw her alive on *Feb 6 1922*and that death occurred, on the date stated above, at *2:30 A.M.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Stomach**Indefinite* (duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Harry Glassman* M. D.*Feb 7 1922* (Address) *2687 Market St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

*MOVAL  
Baltimore City Feb 10 1922*

## 20 UNDERTAKER

## ADDRESS

*Wombach 802 E. 4th*

Exact statement of OCCUPATION should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

61079 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X 3 / 61079

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST.:

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Vera Harriner  
Princess Anne Md. Route 11

## (a) RESIDENCE. NO.

5 N. Chester St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

5

mos.

8

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female White

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

1902

## 7 AGE

19

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

ooo

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Princess Anne  
Maryland

## 10 NAME OF FATHER

Henry Harriner

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Princess Anne  
Maryland

## 12 MAIDEN NAME OF MOTHER

Martha Henderson

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Princess Anne  
Maryland

## 14

Informant  
(Address)

JOHNS HOPKINS HOSPITAL

## 15

Filed

FEB 8 - 1922

ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb 7 - 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Aug 30 - 1921, to Feb 7 - 1922.

that I last saw her alive on Feb 7 - 1922.

and that death occurred, on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH\* was as follows:

Tuberculous colitis

Tuberculous peritonitis

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY  
(Secondary)

none

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

at Princess Anne Md

Did an operation precede death? Yes - 2 - Date of Sept. 4, 1921

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological exam. of tissue

(Signed) Warfield W. Fier, M. D.

1916 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Princess Anne, Somerset Co. Md.

2-8 - 1922

## 20 UNDERTAKER

William Cook.

## ADDRESS

502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61080

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1237 W Cross St. ST. 71 WARD)

## 2-FULL NAME

Loretta Schillenberg

## (a) RESIDENCE

(Usual place of abode) No. 1237 W Cross St. ST. 71 WARD.

Length of residence in city or town where death occurred yrs. 2 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 7, 1921

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 2 6

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

## 10 NAME OF FATHER

Wilbur Schillenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore, Md.

## 12 MAIDEN NAME OF MOTHER

Katherine Smoot

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md.

## 14

Informant (Address)

Mr. Wilbur Schillenberg 1237 W Cross St.

## 15

Filed

FEB 8 - 1922

ROBERT R. KRAUER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-7-1922

17 I HEREBY CERTIFY, That I attended deceased from 2-6-1922, to 2-7-1922,

that I last saw him alive on 2-6-1922,

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH\* was as follows:

Failure of Pericardium  
Oral to Elbow

(duration) yrs. 2 mos. 6 ds.

CONTRIBUTORY (Secondary)

Syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. D. D. M. D.

, 19 (Address) 1237 W Cross St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Landon Park Sec 8

2-8-1922

20 UNDERTAKER

ADDRESS

John P. Cowan &amp; Son

40 N. Holladay St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61081

## CERTIFICATE OF DEATH.

D 61081

## 1-PLACE OF DEATH

Southern Police Station

Registered No. C.....

City of BALTIMORE: (No. Patapsco & Ostend Sts. St. 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....Frederick J. Schnell

35

(Residence in Baltimore: No. Glen Burnie. St.; yrs. .... mos. .... ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, Single (Write the word.)

6-DATE OF BIRTH, July 28th, 1881. (Month) (Day) (Year)

7-AGE, 40 yrs. 6 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Carpenter. (b) General nature of industry, business, or establishment in which employed (or employer), O/S

9-BIRTHPLACE, (State or Country), Philadelphia, Pa.

10-NAME OF FATHER, Frederick Schnell.

11-BIRTHPLACE OF FATHER, (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Mary Winhoff.

13-BIRTHPLACE OF MOTHER, (State or Country), St. Louis, Mo.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), William Schnell. (brother)

(Address), Glen Burnie, Md.

15- FEB 8-1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 5th, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy &amp; Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy &amp; Inquest and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Intra cranial Hemorrhage, Fracture of the skull, inflicted by a blow from an espartoon held in the hands of an officer while in the discharge of his duty. (Duration) yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(Signature) Otto M. Reinhardt, M. D. (Coroner.)

Feb. 3th, 1922. (Address) 1015 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, yrs. .... mos. .... ds. In the State, yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? Patapsco &amp; Cross Sts.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Cedar Hill 2-9-22

20-UNDERTAKER, ADDRESS

E. B. Harb 115 E. West St.

DR. OTTO M. REINHARDT  
1017 S. CHARLES STREET  
PHONE. SOUTH 1093

HOURS:  
8-10 A. M.  
2-4 P. M.  
6-8 P. M.

ADDRESS

February 8th. 1922.

all complete certificate after Inquest.

*Otto M. Reinhardt M.D.*  
Coroner.

Y F. LINDEMAN  
SCRIPTION SPECIALIST  
LES & CROSS STS.

M. D.

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 61082

## CERTIFICATE OF DEATH.

31 D 61082

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

904 N. Castle

ST.:

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Anna Ryba

## (a) RESIDENCE. NO.

904 N. Castle

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

19 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female White

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

July 14th 1902

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

19

8

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Feather worker

(b) General nature of industry, business, or establishment in which employed (or employer)

086

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

## 10 NAME OF FATHER

Anton Ryba

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Bohemia

## 12 MAIDEN NAME OF MOTHER

Anna Ryba

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Bohemia

## 14

Informant

Mollina Ryba

(Address)

904 N. Castle St.

## 15

Filed

FEB 8 - 1922

ROBERT H. KRAUTER,

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb 6 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Nov. 5 1921, to Feb. 6 1922

that I last saw him alive on Jan 5 1922

and that death occurred, on the date stated above, at 3 A. M.

The CAUSE OF DEATH\* was as follows:

Acute Pulmonary I. B.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cordiac Exhaust

(duration) yrs. mos. 2 ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Hyman M. D.

(Address) 802 N. Howard

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Redeemer

## DATE OF BURIAL

Feb 9 1922

## 20 UNDERTAKER

Geo. M. Fink &amp; Son,

## ADDRESS

811 N. Wolfe

General Directors &amp; Embalmers.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



B 61083

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 E 22 1/2 ST ST. 17 WARD)

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

Cesloid

Single a child

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year)

Oct-29-1919

7 AGE

Years

4

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Non

(b) General nature of industry, business, or establishment in which employed (or employer)

Non

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Born in Baltimore

10 NAME OF FATHER

Phillip Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Va

12 MAIDEN NAME OF MOTHER

Lena Harrod

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore City

14

Informant (Address)

Lena Phillipps 402 22 1/2 St

15

FEB 8-1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 5<sup>th</sup>, 1922, to Feb 6<sup>th</sup>, 1922.

that I last saw him live on Feb 6, 1922.

and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia  
following acute Bronchitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY

(Secondary)

Acute Bronchitis

(duration) ? yrs. 3 mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed)

Geo. Hall M. D.

, 19

(Address)

402 E 23 St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Laurel Cemetery

20 UNDERTAKER

Mrs Robert-A Elliott

DATE OF BURIAL

Feb 8 1922

ADDRESS / 725-

Ashland Ave

mation should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE, 091 61084

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2319 Nantux St., 12 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Simon C Jones*

(a) RESIDENCE NO. 2319 Nantux St., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Husband*6 DATE OF BIRTH (month, day, and year) *Feb 3 1922*

7 AGE 5-2 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer*(b) General nature of industry, business, or establishment in which employed (or employer) *Laborer*

(c) Name of employer

9 BIRTHPLACE (city or town) *live in Balt 10 years* (State or country) *live in Wash*10 NAME OF FATHER *Alex Jones*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Wash*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*14 Informant *Marinda Jones* (Address) *2319 Nantux St.*

15 FEB 8 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 6 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 3, 1922, to Feb 6 1922,*that I last saw him live on *Feb 6 1922,*and that death occurred, on the date stated above, at *8:15 p.m.*

The CAUSE OF DEATH\* was as follows:

*Sharp pneumonia*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *no*Did an operation precede death? *no* Date of *no*Was there an autopsy? *no*What test confirmed diagnosis? *Physician Exam*(Signed) *W. H. Hall* M. D., 19 (Address) *411 E. 10th St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Laural Ave**Feb 9 1922*

20 UNDERTAKER

ADDRESS *1725**Mr. Robert A. Elliott* *Adelphi*

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

D 61085

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61085

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1531 N. Pat. Pk. Ave ST. 8 WARD)2-FULL NAME Evelyn M. Vogel(a) RESIDENCE. No. 1531 N. Pat. Pk. Ave WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 13/197 AGE Years 2 Months 2 Days 25 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City (State or country)10 NAME OF FATHER Mr Vogel11 BIRTHPLACE OF FATHER (city or town) MD (State or country)12 MAIDEN NAME OF MOTHER Martha Bender13 BIRTHPLACE OF MOTHER (city or town) MD (State or country)14 Informant Mr Vogel (Address) 1531 N. Pat. Pk. Ave

15 FEB 8 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 19 2217 I HEREBY CERTIFY, That I attended deceased from January 9, 19 22, to February 6, 19 22, that I last saw her alive on February 6, 19 22, and that death occurred, on the date stated above, at 8:30 A. m. The CAUSE OF DEATH\* was as follows:La Grippe(duration) yrs. mos. 12 ds.CONTRIBUTORY Broncho Pneumonia (Secondary)(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Ayer, M. D. Feb 7/22 (Address) 2005 E. Monument St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Schwartz Cem. Feb 7 1922

20 UNDERTAKER

Philip Herwig ADDRESS 2016 Aileaus

Information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61086

61086

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *University Hospital*  
 CITY OF BALTIMORE: (No. *Sanford Green* ST. *5* WARD) REGISTERED NO. *X/53*  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
 2-FULL NAME *Walter C. Slater*  
 (a) RESIDENCE. No. *Frankburg, Md.* ST. *5* WARD.  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. *7* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *child-*  
 5a If married, widowed, or divorced HUSBAND of (or) WIFE of *child-*  
 6 DATE OF BIRTH (month, day, and year) *1915-*  
 7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*7*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *child-*  
 (b) General nature of industry, business, or establishment in which employed (or employer) *1*  
 (c) Name of employer

9 BIRTHPLACE (city or town) *Maryland*  
 (State or country)

10 NAME OF FATHER *Harry C. Slater*

11 BIRTHPLACE OF FATHER (city or town) *Frankburg, Md.*  
 (State or country)

12 MAIDEN NAME OF MOTHER *Frances N. Shipley*

13 BIRTHPLACE OF MOTHER (city or town) *Maryland*  
 (State or country)

14 Informant *University Records-*  
 (Address)

15 Filed *FER 8-1922* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/7* 19 *22*.  
 17 I HEREBY CERTIFY, That I attended deceased from *Feb 1*, 19 *22*, to *Feb 7*, 19 *22*,  
 that I last saw him alive on *Feb 7*, 19 *22*,  
 and that death occurred, on the date stated above, at *10:30 p.m.*  
 The CAUSE OF DEATH\* was as follows:  
*uraemia -*

(duration) yrs. mos. *2* ds.  
 CONTRIBUTORY *Chronic renal disease -*  
 (Secondary) *unknown origin*  
 (duration) yrs. mos. *14* ds.

18 Where was disease contracted *Frankburg, Md.*  
 if not at place of death?

Did an operation precede death? *yes* Date of *2/1/22*

Was there an autopsy?

What test confirmed diagnosis? *Chemical findings*  
 (Signed) *Cyrus J. Harine*, M. D.  
 , 19 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Westminster Md* DATE OF BURIAL *Feb 8 1922*

20 UNDERTAKER *W M Routman* ADDRESS *230 N Greene*

maison should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



61087 HEALTH DEPARTMENT—CITY OF BALTIMORE  
 CERTIFICATE OF DEATH.

44 D 61087

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. 2325 E. Eager ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos.

ds. How long in U. S., if of foreign birth? 1 yr. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Barbara Janeczek

6 DATE OF BIRTH (month, day, and year)

Aug 24-1877

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

44

5

13

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

OIS

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Bohemia

10 NAME OF FATHER

Wincent Janeczek

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Bohemia

12 MAIDEN NAME OF MOTHER

?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

?

14

Informant  
(Address)

15

FEB 8-1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 6 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 1<sup>st</sup>, 1922, to Feb. 6<sup>th</sup>, 1922that I last saw him alive on Feb. 6<sup>th</sup>, 1922

and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY  
(Secondary)

Hemorrhage into bowel

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? 2325 E. Eager St.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X Ray

(Signed) E. Charles Andrew, M. D.

, 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Redeemer

DATE OF BURIAL

Feb 8 1922

20 UNDERTAKER

Paul Crockett

ADDRESS

1966 E. Eager St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61088

## CERTIFICATE OF DEATH.

178 D 61088

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *208 Jasper*)ST.: *4* WARD)

(If death occurred in a hospital or institution, give its NAME (instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *208 Jasper*)St.: *47* yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Male*

## 4-COLOR OR RACE

*Colored*

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)

*Single*

## 6-DATE OF BIRTH,

*Unknown, 1870*  
(Month) (Day) (Year)

## 7-AGE,

*47*

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Laber 40*

## 9-BIRTHPLACE, (State or Country),

*Balto Md*

## 10-NAME OF FATHER,

*Thomas Taylor*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Md*

## 12-MAIDEN NAME OF MOTHER

*Lucy Jones*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Md*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Randoff Wiley*(Address) *208 Jasper St*

## 15-

Filed

*FEB 8 - 1922*

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*Feb. 6, 1922*  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

*Jan 26, 1922*, to *Feb 6, 1922*,that I saw him alive on *Feb 6, 1922*,and that death occurred, on the date stated above, at *6 P. m.*

The CAUSE OF DEATH\* was as follows:

*Bronchial Asthma*(Duration) *0 yrs. 1 mos. 11 ds.*

## CONTRIBUTORY (Secondary)

*Acute Brights*(Duration) *0 yrs. 0 mos. 12 ds.*(Signed) *R. B. Wiley, M. D.**Feb 6, 1922* (Address) *607 W. Franklin St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*mt auburn*

## DATE OF BURIAL,

*Feb 7, 1922*

## 20-UNDERTAKER

*R. B. Gross 1405*

## ADDRESS

*meadow*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Select statement of OCCUPATION in plain terms, so that it may be properly classified. See instructions on back of certificate.

*Phy. states that acute Bright's due to asthmatic condition. No tuberculous. No further history. Not reported in running disease*

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

*lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

*Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.*

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced)*, whether the death is directly or indirectly due to the same.

D 61089

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 Riggs Ave ST. 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1714 Riggs

St. 4 yrs. mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

male

## 4-COLOR OR RACE,

Cul

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

Married

## 6-DATE OF BIRTH,

Feb 2, 1879 (Month) (Day) (Year)

## 7-AGE,

43 yrs. 3 mos. 3 da.

If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

9-BIRTHPLACE,  
(State or Country),

Md

## 10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER  
(State or Country),

Unknown

## 12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER  
(State or Country),

Unknown

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. Lewis

(Address) 1714 Riggs Ave

## 15-

Filed

191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

Feb 5, 1922 (Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Feb 4 - 1922 to Feb 5 - 1922 that I saw him alive on Feb 5 - 1922

and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH\* was as follows:

Acute Bronchitis

(Duration) yrs. mos. da.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. da.

(Signed) Dr. T. Coleman M. D.

Feb 7, 1922 (Address) 2135 E. E. St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutional Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Port Deposit Md Feb 7, 1922

## 20-UNDERTAKER

## ADDRESS

Edward Ringgold 1729 E. E. St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Enter statement of occupation if important. See instructions on back of certificate.



HEALTH DEPARTMENT—CITY OF BALTIMORE  
D 61090

## CERTIFICATE OF DEATH.

D 61090

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal HospitalST.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Watson(a) RESIDENCE. No. 1053 W. Lexington StST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ten yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown6 DATE OF BIRTH (month, day, and year) 18737 AGE Years Months Days If LESS than 1 day, hrs. or min. 48 -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia10 NAME OF FATHER Isaac Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Hospital Records,Municipal Hospital.

15

Filed

FEB 8 - 1922ROBERT N. KRAUTER,

Registrar

Burial Permit Clerk,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3 1922

17

I HEREBY CERTIFY, That I attended deceased from January 9, 19 22, to February 3, 19 22, that I last saw him alive on February 3, 19 22, and that death occurred, on the date stated above, at 6:00 P.M.

The CAUSE OF DEATH\* was as follows:

Footbite gangrene left foot.CONTRIBUTORY (Secondary) Brauco-pneumonia (duration) yrs. 1 mos. ds.(duration) yrs. mos. 4 ds.18 Where was disease contracted if not at place of death? unknownDid an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? Clinical findings(Signed) J. H. Brumback, M. D.2/4/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

NS HUPRINS HUSPITAL20 UNDERTAKER Commissioner Health,ADDRESS FEB 5 - 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61091

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 25 E. Church St. St. 22 Ward)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Williams. (C)

(Residence in Baltimore: No. 25 E. Church St. St. 1 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 4-COLOR OR RACE, 5-Single, Married, Widowed, or Divorced, (Write the word.) Male, Colored, Married

6-DATE OF BIRTH, Do not know, 1 (Month) (Day) (Year)

7-AGE, 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer. (b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), Prince Georges Co. Md.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER, (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Bibbina. (C)

(Address) 25 E. Church St.

15-FEB 8 1922

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 17th, 1922, 1922 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above. (Inquest, autopsy or inquiry.)

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signature) Otto M. Penhard, M. D. (Coroner)

Feb 5, 1922 (Address) 1217 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

HOPKINS HOSPITAL, 1922

20-UNDERTAKER, ADDRESS

Commissioner Health,

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61092

## CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *City Jail*)

ST. *22*

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *James Johnson*

(Residence in Baltimore: No. *400 block S. Charles St. (422 S. Charles)*)

St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*

4-COLOR OR RACE *Col.*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH, *1*

(Month)

(Day)

(Year)

7-AGE, *21*

Yrs. mos. ds.

IF LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Police*  
(b) General nature of industry, business, or establishment in which employed (or employer) *100*

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER, *Police Dept.*

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER *Johnson*

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *[Signature]*

(Address) *[Signature]*

15 *FEB 8 - 1922*

ROBERT R. KRAUTER, Registrar

Burial Permit *18888*

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb 1*, 19*22*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* (Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Pulver Pneumonia*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. J. Riley* M. D. (Coroner.)

*Feb 6*, 19*22* (Address) *1639 Bay*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place *about 6 days* In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL, *1922*

20-UNDERTAKER

ADDRESS

Commissioner *[Signature]*

*FEB - 1922*

Per. Wm. E. W. SCHALL

N. B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

37 61093

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61093

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Harriet Beverly

## (a) RESIDENCE. NO.

1322 Whatead

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

bill

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.

3

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

## 10 NAME OF FATHER

Henry Beverly

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

?

## 12 MAIDEN NAME OF MOTHER

Murrell

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

?

## 14

Informant (Address)

## 15

FEB 8 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk, Commissioner Health.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb 8 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan. 13, 1922, to Feb. 3, 1922,that I last saw him alive on Feb. 3, 1922,and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH\* was as follows:

Early hereditary syphilis

## CONTRIBUTORY (Secondary)

Since birth

(duration) yrs. mos. ds.

None

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

houseDid an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? Wassermann(Signed) Norace G. Stewart, M. D.74, 1922 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

JOHNS HOPKINS HOSPITALFEB 1, 1922

## 20 UNDERTAKER

## ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61094

## CERTIFICATE OF DEATH.

90 D 61094

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Little Sisters of the Poor, St.* 10 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Barbara Roesslein*(a) RESIDENCE NO. *Princeton Valley St.* ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *60* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Joseph Roesslein*

6 DATE OF BIRTH (month, day, and year) *June 1839*

7 AGE Years *83* Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Germany*  
(State or country)10 NAME OF FATHER *Wolfgang Scharold*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)12 MAIDEN NAME OF MOTHER *Barbara*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)14 Informant *Sister Florence*  
(Address) *Princeton Valley*

15 FEB 8 - 1922

ROBERT R. KRAUTER,  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 6* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *No record* 19 to 19that I last saw her alive on *July 6* 19*22*and that death occurred, on the date stated above, at *7* P. M.

The CAUSE OF DEATH\* was as follows:

*Chronic myocarditis**Unknown* (duration) yrs. mos. ds.CONTRIBUTORY *Arterio sclerosis*  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *F. A. Warner*, M. D.19 (Address) *1133 Valley St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Holy Redeemer* *July 10* 19*22*

20 UNDERTAKER ADDRESS

*Jos. J. Herr* *156 Luzerne Ave.*CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-  
TION is very important. See instructions on back of certificates.

D 61095

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61095

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 052 Guttman Ave ST. 9 WARD)

## 2-FULL NAME

(a) RESIDENCE. No. 652 Guttman Ave ST.

(Usual place of abode)

Length of residence in city or town where death occurred

Life

ds.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

(or) WIFE of

Charles Jefferson Christopher

6 DATE OF BIRTH (month, day, and year)

Aug 14, 1875

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

47 yrs

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

John J. Percego

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto

12 MAIDEN NAME OF MOTHER

Eliy Sterling

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant (Address)

Chas. J. Christopher  
652 Guttman Ave

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 24, 1922 to July 7, 1922that I last saw her alive on July 6, 1922and that death occurred, on the date stated above, at 2:30 a. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of uterus

CONTRIBUTORY (Secondary)

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) G. B. [unclear] M. D.Address 15-17 E North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Dr 92 1922

20 UNDERTAKER

ADDRESS

Em. [unclear] 2503 E. [unclear]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

88-1922

61096

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61096

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)  
Length of residence in city or town where death occurred

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed,  
or Divorced (write the word)

single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

B 8-1922

Burial Permit [Blank]

Registrar

ST.

WARD.

(If nonresident give city or town and State)  
ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from

Feb. 6<sup>th</sup>, 1922, to Feb. 7<sup>th</sup>, 1922that I last saw him alive on Feb. 7<sup>th</sup>, 1922,

and that death occurred, on the date stated above, at 4:20 p.m.

The CAUSE OF DEATH\* was as follows:

Rickets

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Electrical Reactions of Ext.

(Signed)

Norace G. Stewart, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61097

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3808 Old Fredk Road*)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred *12* yrs. mos.

## CERTIFICATE OF DEATH.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST.,

WARD.

(If nonresident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Eliza Colvin*

6 DATE OF BIRTH (month, day, and year)

*May 14, 1852*

7 AGE

*69*

Years

Months

*8**23*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Carpenter*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Va.*

10 NAME OF FATHER

*Madison Colvin*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Va.*

12 MAIDEN NAME OF MOTHER

*Sara Harmon*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Va.*

14

Informant (Address)

*Thomas L. Colvin  
3808 Old Fredk. Road.*

15

Filed

*Robert P. J. [unclear]*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 6* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *Feb 3*, 19*22*, to *Feb 6*, 19*22*that I last saw him alive on *Feb 5*, 19*22*, and that death occurred, on the date stated above, at *10 A* m.

The CAUSE OF DEATH\* was as follows:

*Ac Broncho pneumonia*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

19

22

(Address)

*Longfellow*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*London Park*

20 UNDERTAKER

*L. W. Dill*

DATE OF BURIAL

*Feb. 9, 1922*

ADDRESS

*9109 Fredk. Ave.*

F88-1922 Burial Permit Clerk.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61098

## CERTIFICATE OF DEATH.

124 D 61098

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2311 Callow Ave. WARD 13)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Charles Rose Wiley

## (a) RESIDENCE. No.

2311 Callow Ave. ST.

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

73 yrs. 11 mos. 24 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

M

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofAnnie Creamer

## 6 DATE OF BIRTH (month, day, and year)

Feb 11-1848

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.731124

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

Mag. & Toys

(c) Name of employer

Supplies agent9 BIRTHPLACE (city or town)  
(State or country)Baltimore Md.

## 10 NAME OF FATHER

William Wiley11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Baltimore Maryland

## 12 MAIDEN NAME OF MOTHER

Mary Rose13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Queensy Island - B. E.

## 14

Informant  
(Address)Geo. Wiley son  
2500 E. Bay St.

## 15

Filed

Robert F. Harrison,

Registrar

Mirial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 15, 1922, to Feb 7, 1922.that I last saw him alive on Feb 6, 1922.and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH\* was as follows:

Initial myocardial  
coronary insufficiency  
Chr. interstitial nephritis  
? (duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)Malnutrition  
(duration) yrs. mos. ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Stethoscope & X-ray(Signed) Frederick H. McHugh M. D., 19 (Address) 904 W. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Greenmount CemeteryFeb 9 1922

## 20 UNDERTAKER

## ADDRESS

Rev. P. Spencer1325 N. Gandon St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

88-1922

D 61099

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61099

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Municipal Hosp.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.:

WARD)

2-FULL NAME

Michael McCall

(a) RESIDENCE. No.

141 N Gay St.

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

? 1889

7 AGE

32

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

James McCall

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Virginia Copier

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Hosp Records

15

Filed

Robert P. Harrick

19

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-6-1922

17

I HEREBY CERTIFY, That I attended deceased from

2-6-22, 1922, to 2-6-22, 1922,

that I last saw him alive on 2-6-22, 1922,

and that death occurred, on the date stated above, at 7:50 pm.

The CAUSE OF DEATH\* was as follows:

Septic

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Aortic insufficiency (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Clyde McNeill

M. D.

2-8-1922 (Address)

Municipal Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park

Feb. 11, 1922

20 UNDERTAKER

ADDRESS

Wm Coak, 502 E. North ave.

R 8-1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61100

D 61100

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *936 Franklin* ST., *8* WARD)

## 2. FULL NAME

(a) RESIDENCE NO. *936 Franklin* ST., *8* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

1 SEX *Male* 4 COLOR OR RACE *White* 5 Single *Married* Widowed, Divorced, or separatedIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Anna Smith*6 DATE OF BIRTH (month, day, and year) *July 6 - 1855*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work *Painter*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) *Balto Md*10 NAME OF FATHER *Joseph O. Smith*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Baltimore*12 MAIDEN NAME *Mary Truxel*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Baltimore*

14

Informant  
(Address) *Annie Smith*  
*936 Franklin*

15

EB 8-1922

, 19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 8* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from  
*Jan - 3<sup>rd</sup>* 19 *22*, to *Feb 8<sup>th</sup>* 19 *22*  
that I last saw him alive on *Feb 7<sup>th</sup>* 19 *22*  
*645 P.*

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

*Acute Cardiac Dilatation*  
*(not initial myocardial infarction)*CONTRIBUTORY (Secondary) *Chronic Angina* (duration) yrs. mos. ds.  
*10* (duration) *10* yrs. mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *H. O. Grant* M. D., 19 (Address) *1207 Poplar Grove*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Soldon Park*  
*William Cook**2/10 1922*  
*502 E North*

Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

D. 61101

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 61101

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Union Memorial Hosp.

REGISTERED NO.

CITY OF BALTIMORE: (No.

15-14 Division

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Edmund Moore Cudworth Jr.

(a) RESIDENCE. NO.

363 President St. Charleston, S.C.

ST.

WARD.

Charleston S.C.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan. 25 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Charleston S.C.

10 NAME OF FATHER

Edmund Moore Cudworth

11 BIRTHPLACE OF FATHER (city or town) (State or country)

S.C.

12 MAIDEN NAME OF MOTHER

Esther Simms

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

S.C.

14

Informant (Address)

Mrs. Kate M. Cudworth  
Charleston South Carolina

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 8 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 30, 1922, to Feb 9, 1922,

that I last saw him alive on Feb 8, 1922,

and that death occurred, on the date stated above, at 1:10 P.M.

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia

(duration) yrs. mos. / ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb. 8

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Paul W. Sutton M. D.

19 (Address)

U. M. H.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Charleston South Carolina Feb 8 1922

20 UNDERTAKER

ADDRESS

William C. 5028 Nat'l

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

EB 8-1922

Burial Permit No.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Houskeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Operation for correction  
of hare lip.*

D 61102 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61102

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2713 Riggs Ave ST. 16 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Couch

(a) RESIDENCE. NO. 2713 Riggs Ave (Usual place of abode)

ST.

WARD.

Length of residence in city or town where death occurred 45 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct-3-1876

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45

4

5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

John E. Couch.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland.

12 MAIDEN NAME OF MOTHER

Catherine Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland.

14

Informant (Address)

Emma Couch.

2713 Riggs Ave.

15

Filed

19

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb - 8 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Dec 16, 19 21, to Feb 8, 19 22,

that I last saw her alive on Feb 6, 19 22,

and that death occurred, on the date stated above, at 12:50 a. m.

The CAUSE OF DEATH\* was as follows:

Dilatation of heart

(duration) yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Autopsy

(Signed)

Chester Piland.

M. D.

2-8, 1922 Address) 2532 Edmondson Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral

1-11-1922

20 UNDERTAKER

ADDRESS 517

H. B. Manning &amp; Son

Schneider St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

88-1922

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenic," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Probably chronic  
heart disease*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61103

## CERTIFICATE OF DEATH.

90 D 61103

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Burgundy Ct ST. 71 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. 1 Burgundy Ct ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male Col

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant

(Address)

15

88-1922

Burial Permit Clerk

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1922

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

74. 1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Mrs. Katie R. Williams

1114 W. Saratoga St.



D 61104 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61104

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME Mrs Ida Sheffer

(a) RESIDENCE. NO. 506 W. 151<sup>st</sup> St.

(Usual place of abode)

Length of residence in city or town where death occurred

WARD. New York N. Y.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Married

5a If married, widowed, or divorced

(or) WIFE of

Pinkus Sheffer

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

35

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Joseph Lemick

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Mausha Roginsky

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant (Address)

Robert P. Harrison,

15

Full

Burial Permit Clerk.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8<sup>th</sup> 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 23, 1922, to Feb 7<sup>th</sup>, 1922,that I last saw her alive on Feb 8<sup>th</sup>, 1922,and that death occurred, on the date stated above, at 11<sup>20</sup> a.m.

The CAUSE OF DEATH\* was as follows:

Brain tumor (Ependymoma)  
portal colic

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death?

Yes

Date of

Was there an autopsy?

Yes 28<sup>th</sup> 1922

What test confirmed diagnosis?

Autopsy

(Signed)

Gauld Holman M. D.

19 (Address)

Johns Hopkins Hospital

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Joseph Green

2218 2<sup>nd</sup> Ave

D 61105

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61105

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 S Glover ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Norman E. Rieth(Residence in Baltimore: No. 621 S Glover St.; 1 yrs., 1 mos., 18 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single  
(Write the word.)

6-DATE OF BIRTH. Nov 21, 1921  
(Month) (Day) (Year)

7-AGE. 1 yrs., 1 mos., 17 ds. If LESS than 1 day.  
...hrs. or...min.

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. None  
(b) General nature of industry, business, or establishment in which employed (or employer). OOD

9-BIRTHPLACE, (State or Country). City

10-NAME OF FATHER. Chas H. Rieth

11-BIRTHPLACE OF FATHER (State or Country). City

12-MAIDEN NAME OF MOTHER Mary E. Hermann

13-BIRTHPLACE OF MOTHER (State or Country). City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant). Mr Chas H. Rieth

(Address). 621 S Glover St

15-

Robert P. Harrison,

Filed.....

191.....

Registrar.

1922 Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 7, 1921  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 5 1921 to Dec 7 1921,  
that I saw him alive on Dec 7 1921,  
and that death occurred, on the date stated above, at 4 m.  
The CAUSE OF DEATH\* was as follows:

acute gastric intussusception  
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....yrs.....mos.....ds.

(Signed).....M. D.

.....1921 (Address).....

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL, Mount Carmel Feb 2, 1922

20-UNDERTAKER ADDRESS Peter Nicolaus 2046 Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

D 61106

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61106

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 442 E 22nd ST.; 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillie E. Wilson(Residence in Baltimore: No. 442 E 22nd St.; 63 yrs., 7 mos., 13 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE,

White5-SINGLE, MARRIED, Married, WIDOWED, OR DIVORCED, (Write the word.)

## 6-DATE OF BIRTH,

June 25, 1858  
(Month) (Day) (Year)

## 7-AGE,

63 yrs., 7 mos., 13 ds.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work... Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer) 03

## 9-BIRTHPLACE, (State or Country),

Baltimore Md

## 10-NAME OF FATHER,

Alfred D Evens

## 11-BIRTHPLACE OF FATHER (State or Country),

Maryland

## 12-MAIDEN NAME OF MOTHER

Sarah Start

## 13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore Md

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur E Morrison(Address) 347 E 22nd st

## 15-

Filed Robert P. Harrison,

Registrar.

B 8-1922

Marial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

July 7, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1921, to July 7, 1922, that I saw h. 20 alive on July 6, 1922, and that death occurred, on the date stated above, at 11:35 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral - Sclerosis  
(Duration) 1 yrs., 7 mos., 13 ds.

## CONTRIBUTORY (Secondary)

Hypostatic Pneumonia  
(Duration) 1 1/2 mos., 13 ds.  
(Signed) George S. Harrison, M. D.  
July 7, 1922 (Address) 2214 Mayfield Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Greenmount Cemetery

## DATE OF BURIAL,

July 9th, 1922

## 20-UNDERTAKER,

George Schilling & Sons

## ADDRESS

1126 Edmonst

D 61107

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61107

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *535 W. 40<sup>th</sup>* ST., *12* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Anna W. Vollrath*(a) RESIDENCE NO. *535 W. 40<sup>th</sup>*

(Usual place of abode)

ST.,

WARD

Length of residence in city or town where death occurred *60* yrs. mos. ds.How long in U. S., if of foreign birth? *60* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*5a If married, widowed, or divorced  
HUSBAND OF  
(or) WIFE of *Rudolph Vollrath*6 DATE OF BIRTH (month, day, and year) *June 25<sup>th</sup> 1836*7 AGE Years *85* Months *7* Days *13* If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*(b) General nature of industry, business, or establishment in which employed (or employer) *god*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) *Germany*10 NAME OF FATHER *Richard Meyerding*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Germany*12 MAIDEN NAME OF MOTHER *Caroline (Unknown)*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Germany*

## 14

Informant *Mrs Emma Finley*  
(Address) *535 W 40<sup>th</sup> st*

## 15

*Robert P. Harrison,*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 7 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 6 1922* to *Feb 7 1922*that I last saw her alive on *Feb 6 1922*and that death occurred, on the date stated above, at *745 P. m.*

The CAUSE OF DEATH\* was as follows:

*Senility*CONTRIBUTORY  
(Secondary)18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *No*(Signed) *George A. Hoffman, M. D.*756 S. 1922 (Address) *2214 Mayfield Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*London Park Cemetery*

DATE OF BURIAL

*Feb 10<sup>th</sup> 1922*

20 UNDERTAKER

*George Schilling & Sons*

ADDRESS

*426 E Monument*

Exact statement of Occurrence of Death in plain terms, so that it may be properly classified. See instructions on back of certificates.

B8-1922



D 61108

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61108

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *222 E. Hamburg* ST.;

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Charles R. Catterton*

## (a) RESIDENCE. NO.

*222 E. Hamburg* ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Oct. 9-1921*

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*✓**16*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Balto Md.*

## 10 NAME OF FATHER

*Charles Catterton*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Calvert Co. Md.*

## 12 MAIDEN NAME OF MOTHER

*Erin Wisler*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Calvert Co. Md.*

## 14

Informant

(Address)

*Charles Catterton  
222 E. Hamburg St.*

## 15

Filed

*Robert P. Harrison,*

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*Feb 7 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*Jan 24, 1922, to Feb 7, 1922,*that I last saw him alive on *Feb 7, 1922*and that death occurred, on the date stated above, at *6 A.* m.

The CAUSE OF DEATH\* was as follows:

*Tracheo Pneumonia*

(duration)

yrs.

mos.

*14* ds.CONTRIBUTORY  
(Secondary)*Exhaustion*

(duration)

yrs.

mos.

*2* ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *R. H. Campbell* M. D.*Feb 8, 1922* (Address) *1644 Hanover St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Family Cem. Calvert Co. Feb. 10, 1922*

## 20 UNDERTAKER

## ADDRESS

*Margaret G. Flynn 1422 Light St.*

Information should be carefully supplied. Any failure to supply information may result in the certificate being rejected. Exact statement of occupation should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

B 8-1922

D O A K S A F E

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61109

## CERTIFICATE OF DEATH.

D 61109

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2820 Raynor Ave ST.: 16 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Richard Hill

## (a) RESIDENCE. NO.

321 King

ST.,

WARD.

Gloucester City Md.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

1 mos.

7 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed,

or Divorced (write the word)

Single

## 5a If married, widowed or divorced

HUSBAND or

(or) WIFE of

Dec 24 1916

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

555

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Gloucester City  
New Jersey.

## 10 NAME OF FATHER

Hilton R. Hill.

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Penna.

## 12 MAIDEN NAME OF MOTHER

Eleanor Richardson

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Gloucester  
New Jersey.

## 14

Informant

(Address)

Geo B Burrows  
2820 Raynor Ave

## 15

Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 7 1922 to Feb 8 1922that I last saw him alive on Feb 8 1922and that death occurred, on the date stated above, at 12.30 A.M.

The CAUSE OF DEATH\* was as follows:

Laryngeal Diphtheria.

(duration)

yrs.

mos.

2 ds.

## CONTRIBUTORY

(Secondary)

Acute Myocardial  
Degeneration

(duration)

yrs.

mos.

1 ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Yes

Date of

Feb 7 1922

Was there an autopsy?

No

What test confirmed diagnosis?

Throat Culture

(Signed)

Wm Michel

M. D.

Feb 8 1922 (Address)

2901 Edmondson Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Green MountFeb 9 1922

## 20 UNDERTAKER

## ADDRESS

George J. SmithFayette St

mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

B8-1922

Burial Permit Clerk.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61110

D 61110

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Union Memorial Hospital*

REGISTERED NO.

CITY OF BALTIMORE: (No. *1514 Division*)ST.: *19* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *James L. Welch*(a) RESIDENCE No. *1604 W. Fayette St.*

ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *25* mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced *Bertie*  
HUSBAND of *Mrs. James L. Welch*6 DATE OF BIRTH (month, day, and year) *Nov. 20, 1874*7 AGE Years *47* Months *7* Days *18* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Foreman*(b) General nature of industry, business, or establishment in which employed (or employer) *Construction Work*

(c) Name of employer

9 BIRTHPLACE (city or town) *Washington, D.C.*  
(State or country)10 NAME OF FATHER *Roena Welch*11 BIRTHPLACE OF FATHER (city or town) *Va.*  
(State or country)12 MAIDEN NAME OF MOTHER *Hattie Mulford*13 BIRTHPLACE OF MOTHER (city or town) *Virginia*  
(State or country)14 Informant *Reuben Welch*  
(Address) *1604 W. Fayette St.*15 Filed *Feb. 29 1922*

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 7* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *Jan. 20*, 19*22*, to *Feb. 7*, 19*22*, that I last saw him alive on *Feb. 7*, 19*22*, and that death occurred, on the date stated above, at *1 a.* m.

The CAUSE OF DEATH\* was as follows:

*Duodenal Ulcer - 16 yrs.**Intestinal Adhesions - 4 mos.*

(duration) yrs. mos. ds.

CONTRIBUTORY *Pneumonia & Intestinal*  
(Secondary) *Obstruction*

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?*Sept. 19, 1921*Did an operation precede death? *yes* Date of *Jan. 30, 1922*Was there an autopsy? *yes* *Feb. 3, 1922*What test confirmed diagnosis? *Operative*(Signed) *George E. W. Hardy*, M. D.19 Address *Union Memorial Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*St. Paul's Cem. Violetville* *Feb. 9 1922*

20 UNDERTAKER

ADDRESS

*Wm. J. Tickner & Sons* *N. Y. Pa.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

88-1922



D 61111

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61111

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE (No. 1907 N Fulton Ave 5

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Elizabeth D. Bense

## (a) RESIDENCE NO.

1907 N Fulton Ave

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of

Conrad Bense

6 DATE OF BIRTH (month, day, and year)

Dec 5, 1834

7 AGE

Years 87 Months 2 Days 3 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Matthew A. Bense

11 BIRTHPLACE OF FATHER (city or town)

Germany

(State or country)

12 MAIDEN NAME OF MOTHER

Mary Brant

13 BIRTHPLACE OF MOTHER (city or town)

Germany

(State or country)

14

Informant (Address)

Elizabeth D. Bense 1907 N Fulton Ave

15

Filed

Robert J. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8 1922

17 I HEREBY CERTIFY That I attended deceased from Feb. 4<sup>th</sup> 1922 to Feb. 8<sup>th</sup> 1922 that I last saw her alive on Feb. 8<sup>th</sup> 1922 and that death occurred, on the date stated above, at 12 O'clock

The CAUSE OF DEATH\* was as follows:

Heart Myocarditis due to Hypostatic Pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

No Blood

What test confirmed diagnosis?

Analysis of urine

(Signed)

Amelia V. Zimmerman, M. D.

19

(Address) 1805 W North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St Pauls German Lutheran

20 UNDERTAKER

ADDRESS

Wm. J. Hickney &amp; Sons

North Ave

Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



D 61113 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61113

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 St. Balto

ST. 19

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE, No. 1616 St. Balto

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 69. yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

FEB 9-1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Feb 5, 1922, to Feb 6, 1922,

that I last saw him alive on Feb 6, 1922,

and that death occurred, on the date stated above, at 730 A. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) Senile Arteriosclerosis &amp; Chronic Myocarditis

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Henry C. O'Connell

Feb 6 1922 Address 1203 W. Fayette St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

Feb 9 1922

20 UNDERTAKER

ADDRESS

George J. Ruth 1735 Hayford Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61114

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1813 N Dallas St. ST. 8

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Wechselberg

(a) RESIDENCE. NO. 1813 N Dallas St.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of

I. Wechselberg

6 DATE OF BIRTH (month, day, and year)

June 20/1862

7 AGE

60

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

John Welch

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

14

Informant

(Address)

I Wechselberg 1813 N. Dallas St.

15

FEB 9 - 1922

ROBERT N. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 7, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 14, 1922, to Feb. 7, 1922,

that I last saw her alive on Feb. 7, 1922,

and that death occurred, on the date stated above, at 4.45 a.m.

The CAUSE OF DEATH\* was as follows:

General Carcinomatosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 19, '22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

J. O. Ponte, Jr. M. D.

, 19 (Address)

St. Joseph's Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Swaartz Cemetery

Feb 10 1922

20 UNDERTAKER

ADDRESS

George - J. Ruth 1735 Hayford

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Probably originated  
in orary.  
Exploratory laparotomy.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61115

## CERTIFICATE OF DEATH.

38 D 61115

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital

ST.:

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Braderkupp(a) RESIDENCE. No. 223 Freemont Ave

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos.

ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1869

7 AGE

53

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Factory Hand

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Germany

10 NAME OF FATHER

John Kleeg

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER Hannah Stein

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant  
(Address)Hospital Records,  
Municipal Hospital.

15

FEB 9 - 1922

ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5 19 22

17

I HEREBY CERTIFY, That I attended deceased from  
January 6, 19 22, to February 5, 19 22.that I last saw her alive on February 5, 19 22.and that death occurred, on the date stated above, at 4:10 P.M.

The CAUSE OF DEATH\* was as follows:

Syphilis; aortic aneurysm(duration) 1 yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

2/5/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Western Cemetery Feb. 9 19 22  
John J. Cowan Har 901 Hollin

Information should be carefully supplied in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61116

## CERTIFICATE OF DEATH.

D 61116

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 Walsh ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME George Suter

(a) RESIDENCE. NO. 1617 Little Walsh ST. (Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

1 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 3, 1922

7 AGE Years 3 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED Child

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

10 NAME OF FATHER George Suter

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Maryland

12 MAIDEN NAME OF MOTHER William E. Suter

13 BIRTHPLACE OF MOTHER (city or town) Mass (State or country)

14

Informant (Address) Geo. Suter 1617 Little Walsh

15

FEB 9-1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6, 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1922, to Feb 6, 1922, that I last saw him alive on Feb 5, 1922, and that death occurred, on the date stated above, at 5-A m.

The CAUSE OF DEATH\* was as follows:

Premature Birth

(duration) yrs. 7 1/2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History of Case

(Signed) Wm. E. Suter, M. D.

2/6, 1922 (Address) 1837 Penna Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Ave

DATE OF BURIAL Feb 9, 1922

20 UNDERTAKER

ADDRESS 916

Daniel Easton

Rt. 11

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 23477 Pine ST.;

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannah Snowden(Residence in Baltimore: No. 23477 Pine St.;

40 yrs., mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female4-COLOR OR RACE, Col5-SINGLE, Married  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)6-DATE OF BIRTH, Jan 25 1858

(Month)

(Day)

(Year)

7-AGE, 93

yrs. mos. da.

If LESS than 1 day,  
hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular  
kind of work. Housewife  
(b) General nature of industry, business, or establishment in which  
employed (or employer). 0709-BIRTHPLACE,  
(State or Country), Md10-NAME OF  
FATHER, Unknown11-BIRTHPLACE  
OF FATHER  
(State or Country), Unknown12-MAIDEN NAME  
OF MOTHER Unknown13-BIRTHPLACE  
OF MOTHER  
(State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas E. Dorsey(Address) 23477 Pine

15-

FEB 9-1922

ROBERT R. KRAUTER,

Burial Permit

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 6 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 25 1922, to Feb 6 1922,that I saw her alive on Feb 6 1922,and that death occurred, on the date stated above, at 3:05 p.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(Duration) yrs. mos. da.

CONTRIBUTORY  
(Secondary) As shown

(Duration) yrs. mos. da.

(Signed) C. E. Dorsey M. D.Feb 7, 1922 (Address) 712 S. Broadway

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

National CemFeb 9, 1922

20-UNDERTAKER

ADDRESS

Sam W. Chase400 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly entered. See instructions on back of certificate.



THIS IS TO CERTIFY that on this 18<sup>th</sup> day of February, 1922,  
before me, the subscriber, a Notary Public, in and for the City  
of Baltimore, State of Maryland, personally appeared CHARLES H.  
FOWLER, M. D. and made oath in due form of law that Hannah Snowden  
234 N. Pine Street is 93 instead of 63 years of age.

Minnie B. Lewis  
Notary Public.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61118

D 61118

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 Ettiing ST. 11 WARD)

## 2-FULL NAME Eliza Shunklin

(a) RESIDENCE. No. 1212 Ettiing ST. 17 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

married

6 DATE OF BIRTH (month, day, and year)

11/11/1901

7 AGE 71

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

md.

10 NAME OF FATHER

William married

11 BIRTHPLACE OF FATHER (city or town) (State or country)

md.

12 MAIDEN NAME OF MOTHER

mariah dee

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

md.

14

Informant (Address)

James Shanklin 1212 Ettiing ST

15

FEB 9-1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 6 1922

17

I HEREBY CERTIFY, that I attended deceased from

Aug 30, 1921, to Feb 4, 1922

that I last saw her alive on Feb 4, 1922

and that death occurred, on the date stated above, at 1030 m.

The CAUSE OF DEATH\* was as follows:

Mitral Insufficiency

CONTRIBUTORY (Secondary)

Exhaustion 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. B. Hughes, M. D.

7/19/22 Address 1413 S. Full St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

mt Auburn Cemetery

Feb 9 1922

20 UNDERTAKER

ADDRESS

John H. Toddman

142 White St

61119

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61119

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO 2023 E. Monument

ST.:

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate D. Van Rossum

(a) RESIDENCE. NO 2023 E. Monument

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 6 mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

William E. Van Rossum

6 DATE OF BIRTH (month, day, and year) Sept. — 1851

7 AGE Years 71 Months 6 Days — If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland

10 NAME OF FATHER ———— Plummer

11 BIRTHPLACE OF FATHER (city or town) Maryland  
(State or country)

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) Do not know  
(State or country)14 Informant Wm. L. Van Rossum  
(Address) 2023 E. Monument StreetROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1922

17

I HEREBY CERTIFY, That I attended deceased from

January 1920, to February 7, 1922,

that I last saw her alive on February 7, 1922,

and that death occurred, on the date stated above, at 4:15 A. M.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Frank J. Ayd, M. D.

2/7, 1922 (Address) 2005 E. Monument St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Carmel Cemetery

2/9, 1922

20 UNDERTAKER

ADDRESS

Henry W. Mears &amp; Son 805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61120

## CERTIFICATE OF DEATH.

52 D 61120

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *12* ST.: *12* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Sarah Belle Renno* Sarah Belle Renno

## (a) RESIDENCE. NO.

*2928 8th Ave*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Married*

## 5a If married, widowed, or divorced

~~HUSBAND~~  
(or) WIFE of*John Robert Renno*

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than  
1 day... hrs.  
or min.*69*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Washington DC*

## 10 NAME OF FATHER

*Geo W. White*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Pa*

## 12 MAIDEN NAME OF MOTHER

*Sarah Belle Renno*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Pa*

## 14

Informant  
(Address)*Maryland General Hospital  
Linden Ave. & Madison St.*

## 15

FEB 9-1922

ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 7* 19*22*

## 17

I HEREBY CERTIFY, That I attended deceased from

*2/4/22*, 19*22*, to *2/7/22*, 19*22*.that I last saw her alive on *2/7/22*, 19*22*.and that death occurred, on the date stated above, at *7:15 P* m.

The CAUSE OF DEATH\* was as follows:

*Heart*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) 1 yrs. 6 mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed)

19 (Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Green Mount Cemetery

2/10, 22

## 20 UNDERTAKER

## ADDRESS

Henry W. Mears &amp; Son 805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Starvation due to  
malnutrition. No cancerous  
condition. No further history.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61121

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 Park Ave

ST.: 11 WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 1016 Park Ave, ST.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female Colored married  
If married, widowed, or divorced, HUSBAND of (or) WIFE of Robert Snowden

6 DATE OF BIRTH (month, day, and year) Feb 7-1893

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
29 — —

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

FEB 9-1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1922, to Feb. 7, 1922, that I last saw her alive on Feb. 6, 1922, and that death occurred, on the date stated above, at 5:15 a. m.

The CAUSE OF DEATH\* was as follows:

Mitral regurgitation

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Gastric catarrh (duration) yrs. mos. ds.

18 Where was disease contracted (If not at place of death?) Balto. Md

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. C. Robinson, M. D.

Address 1520 Monument St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Lykesville Home Bldg Feb 10 1922

UNDERTAKER

Geo. A. Holland

ADDRESS 1631

Kendall

Information should be furnished in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61122

## CERTIFICATE OF DEATH.

D 61122

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

912 Park av

ST.

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Benjamin Harrod

(a) RESIDENCE. NO.

912 Park av

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Rachel Harrod

6 DATE OF BIRTH (month, day, and year)

Feb 6, 1862?

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

60

—

2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

Serving Food

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

West River Md

10 NAME OF FATHER

Richard Harrod

11 BIRTHPLACE OF FATHER (city or town) (State or country)

West River Md

12 MAIDEN NAME OF MOTHER

Sallie Watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

West River

14

Informant (Address)

Rachel Harrod 912 Park av.

15

Filed

19

ROBERT R. KRAUTER Registrar

FEB 9-1922

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 7 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 6 1922, to Feb 7 1922

that I last saw him alive on Feb 7 1922,

and that death occurred, on the date stated above, at 11:55 A. M.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Cystic Tumors

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Examination of Hoppins

(Signed)

Wm. A. Wright

8, 19

22

(Address)

1509 Park av.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Auburn Cem

DATE OF BURIAL

Feb 10 1922

20 UNDERTAKER

G. H. Holland

ADDRESS

1631 Walnut Hall

## HEALTH DEPARTMENT—CITY OF BALTIMORE, D 61123

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4816 Park Heights ST., 27 WARD)

## 2-FULL NAME Maurice A Brooks Jr

(a) RESIDENCE NO. 4816 Park Heights ST.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

W

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 3, 22

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Balto Md.

10 NAME OF FATHER Maurice A Brooks

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Balto Md.

12 MAIDEN NAME OF MOTHER Elsie B Bussell

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Baltimore Md.

14

Informant  
(Address)Maurice A Brooks  
4816 Park Heights

15

FFR 9-1922 JEM

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 3, 1922, to Feb 8, 1922.

that I last saw him alive on Feb 8, 1922.

and that death occurred, on the date stated above, at 9 9 m.

The CAUSE OF DEATH\* was as follows:

Infantile Volvulus Acute  
Intoxication

(duration) yrs. mos. 5 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? 4816 Park Heights

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. B. Bussell, M. D.

1922 (Address) 4816 Park Heights

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt Olivet Cemetery

Feb 9 1922

20 UNDERTAKER

ADDRESS

W. Maurine Routhon

2238 N. North Ave



D 61124

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

164 D 61124

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2528 W. Balto.

ST.: 20 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Rynck G. Smith

(Residence in Baltimore: No.

2528 W Balto St

St.: 74 yrs., 7 mos., 26 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

## 6-DATE OF BIRTH,

June

11

1847

(Month)

(Day)

(Year)

## 7-AGE,

74

yrs.

7

mos.

26

ds.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Elevator

(b) General nature of industry, business, or establishment in which employed (or employer).

Inspector

## 9-BIRTHPLACE,

(State or Country),

Balto Md

## 10-NAME OF FATHER,

Wm Smith

## 11-BIRTHPLACE OF FATHER

(State or Country),

Balto. Md

## 12-MAIDEN NAME OF MOTHER

Margaret Hand

## 13-BIRTHPLACE OF MOTHER

(State or Country),

Balto Md

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Rynck Smith

(Address).

2528 W Balto St

## 15-

Filed SEP 9-1922

191

J. E. M. Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Feb.

7

1922

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Nov. 27, 1921, to Feb. 7, 1922,

that I saw him alive on Feb. 7, 1922,

and that death occurred, on the date stated above, at 4:40 p. m.

The CAUSE OF DEATH\* was as follows:

Coronary Sclerosis

and other

(Duration).....yrs.....mos.....ds.

## CONTRIBUTORY (Secondary)

Slight Debility

(Duration).....yrs.....mos.....ds.

(Signed) J. E. M. Registrar

2/9, 1922 (Address) 905 N. E. St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Landon Park Cemetery

Feb. 10, 1922

## 20-UNDERTAKER

## ADDRESS

H. M. Rouse

2230 North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61125

## CERTIFICATE OF DEATH.

90 D 61125

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

ST.

WARD)

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

FEB 9-1922

ROBERT R. KRAUTER,  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2. 8. 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6 to Feb. 8, 1922

that I last saw him alive on Feb. 7, 1922

and that death occurred, on the date stated above, at 6:50 A. m.

The CAUSE OF DEATH\* was as follows:

Acute Tubercular Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Brothel death

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. K. M. M. D.

(Address) 1031 N. Caroline St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lindus Park, Md. Feb 10 1922

20 UNDERTAKER

ADDRESS

Robt. Thuermer Du 14 1922

43 Bmoy

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 61126

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61126

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1030 W. Payson* ST. *18* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME. *Lewis H. White Jr.*(a) RESIDENCE NO. *1030 W. Payson* ST. *18* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *4* yrs. *6* mos. *15* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 23<sup>rd</sup> 1917*7 AGE Years Months Day If LESS than 1 day, hrs. or min. *4* *6* *15*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto. Md.* (State or country)10 NAME OF FATHER *Lewis H. White Jr.*11 BIRTHPLACE OF FATHER (city or town) *U. S.* (State or country)12 MAIDEN NAME OF MOTHER *Maggie White*13 BIRTHPLACE OF MOTHER (city or town) *U. S.* (State or country)14 Informant *Lewis H. White Jr.* (Address) *1030 W. Payson St.*15 Filed *Robert P. Harrison,* Registrar

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 7<sup>th</sup> 1922*17 I HEREBY CERTIFY, That I attended deceased from *Feb. 5*, 1922, to *Feb. 7*, 1922, that I last saw him alive on *Feb. 7*, 1922,and that death occurred, on the date stated above, at *7<sup>30</sup> P. M.*

The CAUSE OF DEATH\* was as follows:

*Bronchitis Acute.*(duration) yrs. mos. *3* ds.CONTRIBUTORY *Cardiac dilatation acute.* (Secondary)(duration) yrs. mos. *Short.*18 Where was disease contracted if not at place of death? *✓*Did an operation precede death? *No* Date of *✓*Was there an autopsy? *No*What test confirmed diagnosis? *✓*(Signed) *George C. Shannon* M. D.*2/8, 1922* (Address) *700 Fulton Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Balto. Cemetery*

DATE OF BURIAL

*Feb. 9<sup>th</sup> 1922*20 UNDERTAKER *Lilly & Giller*

ADDRESS

*4002 Maple St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

9-1922

Burial Permit Clerk.

D 61127

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61127

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 7 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mrs. Constance Greer

## (a) RESIDENCE. No.

60 Chestnut Park Rd. Toronto Canada

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos. 4

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofJohn W. Greer

## 6 DATE OF BIRTH (month, day, and year)

1887

## 7 AGE

Years

Months

Days

If LESS than  
1 day, \_\_\_\_ hrs.  
or \_\_\_\_ min.34

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Toronto Canada

## 10 NAME OF FATHER

Lawrence Turnbull

## 11 BIRTHPLACE OF FATHER (city or town)

Scotland

(State or country)

## 12 MAIDEN NAME OF MOTHER

Elizabeth Kay

## 13 BIRTHPLACE OF MOTHER (city or town)

Toronto Can.

(State or country)

## 14

Informant  
(Address)JOHNS HOPKINS HOSPITAL

## 15

Filed

Robert P. Harrison

Registrar

Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) — 2-8 1922

17

I, HEREBY CERTIFY, That I attended deceased from  
Feb 6 1922, to Feb 8 1922that I last saw her alive on Feb 8 1922, atand that death occurred, on the date stated above, at 10 0 m.

The CAUSE OF DEATH\* was as follows:

Hepatic Insufficiency  
Cirrhosis of Liver(duration) \_\_\_\_ yrs. 10 mos. \_\_\_\_ ds.CONTRIBUTORY  
(Secondary)

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

18 Where was disease contracted  
if not at place of death?Unknown

Did an operation precede death?

Yes

Date of

Feb 6 1922

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

, 19 \_\_\_\_ (Address)

Paul Holman M. D.  
Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Toronto Canada

## DATE OF BURIAL

2-9-22

## 20 UNDERTAKER

Henry J. Denton

## ADDRESS

1000

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



D 61128

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61128

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1805 N. Calvert* ST. *12* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Eliza W. Weems*  
(a) RESIDENCE. NO. *1805 N. Calvert* ST., WARD.(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*86*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

*Robert P. Harrison*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/8* 19*22*

17 I HEREBY CERTIFY, That I attended deceased from

*2/6* 19*22* to *2/8* 19*22*  
that I last saw him alive on *2/8* 19*22*  
and that death occurred, on the date stated above, at *6:00* m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary Embolus*CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. *2* ds.  
*Endocarditis*  
(duration) yrs. mos. ds. *7* ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical findings*

(Signed)

2/9/22

(Address)

1009 Cathedral

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Lorraine Cem**2-8-22*

20 UNDERTAKER

*Henry Jenkins & Sons Co*

ADDRESS

*1009 Cathedral*

Information should be carefully supplied so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

B-1-1922

D 61129

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61129

## CERTIFICATE OF DEATH.

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2)

2-FULL NAME

(Residence in Baltimore: No. 2)

ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. 44 mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)

6-DATE OF BIRTH,

7-AGE

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

15-

Robert P. Harrison,

191

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, that I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry

And that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Coroner)

191 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the  
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

B 9-1922

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61130

## CERTIFICATE OF DEATH.

D 61130

### PLACE OF DEATH

CITY OF BALTIMORE (No. 1231 Mt. Royal Ave ST. 11 WARD)

2-FULL NAME Robt. W. Hutchins

(Residence in Baltimore: No. 1231 Mt. Royal Ave)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 49 yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male 4-COLOR OR RACE, white 5-SINGLE, married, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Feb. ?, 1873 (Month) (Day) (Year)

7-AGE, 49 yrs., ? mos., ? ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Marine Engineer (b) General nature of industry, business, or establishment in which employed (or employer), 1230

9-BIRTHPLACE, (State or Country), Md.

10-NAME OF FATHER, Lewis K. Hutchins

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Catherine Kennedy

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. L. D. Hutchins

(Address) 142 W. Calver Ave.

15- Robert P. Harrison,

Filed 1922 Burial Permit Clerk Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 8, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry,) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry,) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows: Suicide by gas inhalation (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (Duration) ... yrs. ... mos. ... ds. (Signed) J. J. Hennerty M. D. (Coroner.) Feb. 9, 1922 (Address) 2822 Calver Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place In the of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds. Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Greenwood Park Cemetery DATE OF BURIAL, Feb. 10, 1922

20-UNDERTAKER, Henry W. Means & Son ADDRESS, 705 W. Calver Ave.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61131

D 61131

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2830 Guilford Ave.

ST. 12 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rose Hull

(a) RESIDENCE. No. 2830 Guilford Ave  
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8, 1855

7 AGE Years 66 Months 9 Days 1 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland

10 NAME OF FATHER W. G. V. Hull

11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Henrietta Hugg

13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country) Maryland14 Informant W. G. V. Hull  
(Address) 2830 Guilford Ave

15 Filed Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9, 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1922 to Feb 9, 1922 that I last saw him alive on Feb 9, 1922 and that death occurred, on the date stated above, at 7:00 A. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Oedema secondary to Chronic Valvular Endocarditis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

Chronic Hypertension (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. J. Harrison, M. D.

49, 1922 (Address) 2844 St. Paul

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery

2-11-22 19

20 UNDERTAKER

ADDRESS

H. E. Hughes

424 N. Broadway

B9-1922 Burial Permit Clerk



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61132

D 61132

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1511* *Clamont* ST.; *16* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *1511* *Clamont* St.; *40* yrs., *3* mos., *19* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE

*White*

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

*Married*

## 6-DATE OF BIRTH,

*Oct 15, 1899*  
(Month) (Day) (Year)

## 7-AGE,

*40* yrs., *3* mos., *19* ds.If LESS than 1 day,  
... hrs. or ... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*

## 9-BIRTHPLACE, (State or Country),

*Balto Md*

## 10-NAME OF FATHER,

*Chas W Taylor*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Balto Md*

## 12-MAIDEN NAME OF MOTHER

*Elmira Ireland*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Balto Md*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *S. W. Weeks*(Address) *1511 Clamont St.*

## 15-

*Robert P. Harrison,*

Filed....., 191.....

1922

Burial Permit Clerk, Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Feb 7, 1922*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Feb 4<sup>th</sup>* 1922, to *Feb 7<sup>th</sup>* 1922,that I saw h *er* alive on *Feb 7<sup>th</sup>* 1922, and that death occurred, on the date stated above, at *9:30 P.* m.

The CAUSE OF DEATH\* was as follows:

*Congestive heart failure - repeated attacks for*  
(Duration)..... yrs..... mos..... ds. *4*

## CONTRIBUTORY (Secondary)

*Myocarditis (?)*  
(Duration)..... yrs..... mos..... ds. *6*  
(Signed) *Chas W Taylor* M. D.  
*2-7-22*, 191... (Address) *3123 W. North Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Western Cemetery Feb 10, 1922*

## 20-UNDERTAKER

## ADDRESS

*Chas E. Franck 812 Madison St*

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61133

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

517 Rosette Ave

ST. 27

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

John L. Kears

## (a) RESIDENCE. NO.

517 Rosette Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Widowed

## 5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Lattie Kears

## 6 DATE OF BIRTH (month, day, and year)

Mar. 17 - 1848

## 7 AGE

Years 73

Months 10

Days 22

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salesman obb

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Virginia

## 10 NAME OF FATHER

John V. Kears

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

## 12 MAIDEN NAME OF MOTHER

Mary Hart

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

## 14

Informant (Address)

Mrs. Sawyer 517 Rosette Ave

## 15

Filed

19

Robert F. HARRISON, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9 1922

17 I HEREBY CERTIFY, That I attended deceased from November 1920, to Feb. 9, 1922,

that I last saw him alive on Feb. 8, 1922,

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH\* was as follows:

Chronic interstitial nephritis

(duration) 2 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) W. C. Kears, M. D.

2-9, 1922 Address 5600 York Rd. Baltimore Md

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

London Park Cem Co

Feb 11 1922

## 20 UNDERTAKER

## ADDRESS

Chas. E. Franck

807 Madison Ave

See instructions on back of certificates.

39-1922

Serial Permit Blank

D 61134

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61134

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 N Port ST., 6 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(s) RESIDENCE NO.

(Usual place of abode)

ST.,

WARD

Length of residence in city or town where death occurred Life yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? Life yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female white Widow

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

August Gerlach

6 DATE OF BIRTH (month, day, and year)

Dec 28-1862

7 AGE

68 Years

Months

1

Days

10

If LESS than 1 day, .... hrs or .... min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

John Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

May Hollander

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant

(Address)

Elizabeth Youngs  
419 N Port St

15

Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 10, 1920, to Feb 7, 1922.

that I last saw him alive on Feb 4, 1922.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH was as follows:

Scarlet fever

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

C line of

(Signed)

R. P. Harrison M. D.

Res. 1921 (Address) 2600 E Baltimore

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL

Oak Lawn Cemetery

Feb 10 1922

20 UNDERTAKER

ADDRESS

Mrs C. Miller

2334 Jeffers

Exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificates.

9-1922

Bristol Permit Clerk

D 61135

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61135

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

508 N. Carey

ST.

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Allison S. Swartz

(Residence in Baltimore: No.

508 N. Carey

St.; 10 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female white

## 4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

## 6-DATE OF BIRTH

March 12, 1952  
(Month) (Day) (Year)

## 7-AGE,

69 yrs., mos. ds.

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Retired

## 9-BIRTHPLACE,

(State or Country), Pa

## 10-NAME OF FATHER,

Charles Swartz

## 11-BIRTHPLACE OF FATHER (State or Country),

Pa

## 12-MAIDEN NAME OF MOTHER

Catherine Kesper

## 13-BIRTHPLACE OF MOTHER (State or Country),

Pa

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Gorgas

(Address)

508 N. Carey St.

## 15-

Robert P. Harrison,

191

Registrar.

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Feb 8, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Feb 7, 1922, to Feb 8, 1922,

that I saw her alive on Feb 8, 1922,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Heart Disease

(Duration) mos. ds.

## CONTRIBUTORY.

Heart Failure

(Signed) John H. Brown M. D.

Feb 8, 1922 (Address) 141 N. Carey

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Harrisburg Pa Feb 11, 1922

## 20-UNDERTAKER

## ADDRESS

Chas. E. Hancock 822 Madison

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

89-1922



D 61136

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61136

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *910 Boyd* ST. *18* WARD)2-FULL NAME *Eva May Alston*(a) RESIDENCE. NO. *910 Boyd* ST. *18* WARD.(Usual place of abode)  
Length of residence in city or town where death occurred *Life*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Married*  
6a If married, widowed, or divorced (or) WIFE of *Herbert Alston*6 DATE OF BIRTH (month, day, and year) *Nov 9, 1885*7 AGE Years *36* Months *2* Days *29* If LESS than 1 day, hrs. or min.8 OCCUPATION OF DECEASED  
(a) Trade, profession or particular kind of work *General Housework*  
(b) General nature of industry, business, or establishment in which employed (or employer) *037*  
(c) Name of employer9 BIRTHPLACE (city or town) *Towson Ind*  
(State or country)10 NAME OF FATHER *George Stevenson*11 BIRTHPLACE OF FATHER (city or town) *S.C.*  
(State or country)12 MAIDEN NAME OF MOTHER *Deby Johnson*13 BIRTHPLACE OF MOTHER (city or town) *Bovaustown Ind*  
(State or country)14 Informant *Nellie Boyer*  
(Address) *910 Boyd St*15 *Robert T. Harrison,* Registrar1922 *Burial Permit Clerk.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 7, 1922*17 I HEREBY CERTIFY, That I attended deceased from *Feb 5*, 1922 to *Feb 7*, 1922, that I last saw him alive on *Feb 7*, 1922, and that death occurred, on the date stated above, at *7:25 p.m.*  
The CAUSE OF DEATH\* was as follows:  
*Nephritis*CONTRIBUTORY (Secondary) *Endocarditis*  
(duration) *3* yrs. *3* mos. *3* ds.18 Where was disease contracted  
If not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis?  
(Signed) *W. H. Havill* M. D.2/8, 1922 (Address) *1194 Carrollton Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *McLachlan Co* DATE OF BURIAL *Feb 12*20 UNDERTAKER *Daniel E. Taylor* ADDRESS *916*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61137

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3149 Leeds St. 70 WARD)

## 2-FULL NAME

Henry Kroll

## (a) RESIDENCE. NO.

3149 Leeds

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? 65 yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Emma Kroll

## 6 DATE OF BIRTH (month, day, and year)

Sept 16, 1857

## 7 AGE

71

Years

Months

4

Days

23

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Germany

## 10 NAME OF FATHER

Geo. Kroll

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Kubman

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Germany

## 14

Informant  
(Address)

Emma Kroll

## 15

Filed

Robert P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1922

I HEREBY CERTIFY, That I attended deceased from

Oct 20 1918, to Feb. 8 1922

that I last saw him alive on Feb. 7 1922

and that death occurred, on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH\* was as follows:

Acute Myocardial Insufficiency

CONTRIBUTORY  
(Secondary)Arteriosclerosis  
Valvular Heart Disease18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W. Jones M.D.

F. 9. 1922 Address) Dr. Wright

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION, or REMOVAL

Mt. Olivet

DATE OF BURIAL

Feb 11, 1922

20 UNDERTAKER

George J. Smith

ADDRESS

1000 W. Fayette St.

FEB 9-1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61138

D 61138

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3310 Carlisle Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Emily Sindall(Residence in Baltimore: No. 3310 Carlisle Ave)St. 91 yrs., 11 mos., 18 da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, married (Write the word.)6-DATE OF BIRTH, February 22, 1890 (Month) (Day) (Year)7-AGE, 91 yrs., 11 mos., 18 da. If LESS than 1 day, ... hrs. or ... min.8-OCCUPATION: (a) Trade, profession, or particular kind of work, none (b) General nature of industry, business, or establishment in which employed (or employer), none9-BIRTHPLACE, (State or Country), Baltimore, Md10-NAME OF FATHER, Johnathan Isaacs11-BIRTHPLACE OF FATHER, (State or Country), Prince Geo. Co Md12-MAIDEN NAME OF MOTHER, Ann Thompson13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herbert Dawkins(Address) 3310 Carlisle Ave

15-

Filed 191 Robert E. HARRISON, Registrar.

39-1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 9, 1922 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from February 2 1922, to February 9 1922, that I saw him alive on February 8 1922, and that death occurred, on the date stated above, at 4:15 p. m. The CAUSE OF DEATH\* was as follows:Astero. Sclerosis  
Chronic Interstitial Nephritis  
(Duration) 2 yrs., 11 mos., 18 da.CONTRIBUTORY Acute Bronchitis  
(Secondary) (Duration) 7 yrs., 11 mos., 18 da.(Signed) Robert E. Harrison M. D.  
Feb 9, 1922 (Address) 1227 Lafayette St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, 11 yrs., 11 mos., 18 da. In the State 11 yrs., 11 mos., 18 da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Oliver DATE OF BURIAL, Feb. 11, 192220-UNDERTAKER, George J. Smith ADDRESS 1000 N. 25th St

D 61139

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61139

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *873 N Fayette* ST. *18* WARD)2-FULL NAME *Joseph R. Campbell*(a) RESIDENCE. NO. *873 N Fayette* ST. *18* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *1* mos. *6* ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Male White Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Jan 3/1922*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*1 6*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*none*

9 BIRTHPLACE (city or town) (State or country)

*Balto Md*10 NAME OF FATHER *Wm Campbell*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balto Md*12 MAIDEN NAME OF MOTHER *Flora Chindley*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*M. C*

14

Informant (Address)

*Wm Campbell 873 N Fayette St.*

15

Filed

*Robert P. Harrison,*

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 9 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar 7 1922 to Feb 9 1922*

that I last saw him alive on

and that death occurred, on the date stated above, at *1-30 A.M.*

The CAUSE OF DEATH\* was as follows:

*Gastro Enteritis*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed death?

*signed R. P. Campbell, M.D.**1644 Dawson St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park Cem**Feb 10 1922*

20 UNDERTAKER

ADDRESS

*Geo. J. Smith**873 N Fayette*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

89

1922

F  
A  
S  
S  
A  
K  
A  
D  
O



D 61140 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61140

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. V. Hospital #56  
CITY OF BALTIMORE: (No. Ft. McHenry, Baltimore ST. WARD)

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar R. Vessells

(a) RESIDENCE NO. Ft. McHenry, Baltimore, ST. WARD  
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of Mrs. E.R. Vessells (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 64 -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stewart

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant E.T. Rosenbrock Registrar (Address)

15 Robert P. Harrison, Registrar (Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 31, 1922 to Feb. 7, 1922.

that I last saw him alive on Feb. 7, 1922, 19

and that death occurred, on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH\* was as follows:

Apoplexy (Brain Haemorrhage)  
Cerebral

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) -- (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. H. Gordon, M. D.

19 (Address) USV Hospital #56, Balto. Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

MOVING Mt Auburn Cemetery 2/11/1922

20 UNDERTAKER ADDRESS

Philip B. Beyer 102 E. Mulberry St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

D 61141

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61141

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1420 W. Mosher

ST.: 16

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Eugenia Wilson

## (a) RESIDENCE

No. 1420 W. Mosher

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

19

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

F

## 4 COLOR OR RACE

C.

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

unknown 1902

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

19

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housemaid

(b) General nature of industry, business, or establishment in which employed (or employer)

070

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

T. B. C.

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

## 14

Informant

(Address)

Edna Wilson

1420 Mosher St.

## 15

Filed

Robert F. Barlaen,

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb 7 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan 20, 1922, to Feb 7, 1922,

that I last saw him alive on

Feb 7, 1922,

and that death occurred, on the date stated above, at

3 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration)

yrs.

6 mos.

ds.

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death?

No

Date

No

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. H. H. H.

(Address)

939 W. Fayette

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Surrey Cemetery Feb 10/22

## 20 UNDERTAKER

## ADDRESS

Robert E. Perkins

1106 Ashland

B 9-1922

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

D 61142

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61142

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO Municipal Tuberculosis Hospital ST. 14 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Savage

(a) RESIDENCE. NO. 734 Wilson st.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mes. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902 Oct 4 7 AGE Years Months Days 19 4 5 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

## 9 BIRTHPLACE (city or town) (State or country)

North Carolina

10 NAME OF FATHER Chas. Savage

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Lucille Peace

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country) North Carolina

## 14 Informant Hospital Records

(Address) M.T.H.

15 Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1921, to Feb. 9, 1922, that I last saw him alive on Feb. 8, 1922,

and that death occurred, on the date stated above, at 2:30 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY Pneumothorax (Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? R. in sputum

(Signed) Francis F. Fagan, M. D.

2-9-22 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Henderson North Carolina Feb 10 1922

20 UNDERTAKER

ADDRESS

Charles Wright, 1364 Maryland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

B 9-1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61143

## CERTIFICATE OF DEATH.

100 D 61143

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

1 yrs. 4 mos. 11 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept. 28-1920

7 AGE

1 Years 4 Months 11 Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Giorgio Ruvoizzo

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

12 MAIDEN NAME OF MOTHER

Laura Cortis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Italy

14

Informant (Address)

Giorgio Ruvoizzo 1215 McElderry St.

15

Filed

-1922

Robert P. Harrison, Registrar

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 8 1922

17

I HEREBY CERTIFY, That I attended deceased from

24 5, 1922, to 24 8, 1922.

that I last saw him alive on

24 8, 1922

and that death occurred, on the date stated above, at

h m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Cem.

Feb 10 1922

20 UNDERTAKER

Geo. J. Ruth

ADDRESS

1708

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior.*  
1918

D 61144 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61144

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2650 N. North ave ST. 15 WARD)

## 2-FULL NAME

Agnes V. Bowen

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

2650 N. North ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female white Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1859

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 62

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co. (State or country) Md.

10 NAME OF FATHER Vergil Bowen

11 BIRTHPLACE OF FATHER (city or town) Cal. Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Carr

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant William F. Bockmiller (Address) 2650 N. North ave

15 Robert F. Harrison, Registrar

3 N. North ave

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 6 1922, to Feb 7 1922, that I last saw her alive on Feb. 7 1922

and that death occurred, on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) R. C. Metzger M. D.

2/8, 1922 (Address) 1903 W. North ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

20 UNDERTAKER ADDRESS

J. M. Cook, 502 E. North ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61145

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *md Gen Hosp* ST. *12* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Henry Voland*(a) RESIDENCE. No. *2120 md Ave* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mrs Anna Voland*6 DATE OF BIRTH (month, day, and year) *4/8/22*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Receptionist*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto*10 NAME OF FATHER *Henry Voland*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto*12 MAIDEN NAME OF MOTHER *Eliz. Moore*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto*

14

Informant (Address) *Anna Voland 2120 Maryland Ave*

15

Filed *Robert P. Harrison,* Registrar

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/8/22* 19

17

I HEREBY CERTIFY, That I attended deceased from

*1.14.22*, 19, to *4/8/22*, 19,that I last saw him alive on *4/8/22*, 19,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

*Pneumonia Congestive*

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *No*What test confirmed diagnosis? *Chest X-ray*(Signed) *Dr. J. M. Harrison* M. D., 19 (Address) *1000 N. E. St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Western Cemetery Feb 11 22*

20 UNDERTAKER

ADDRESS

*William Calver & Co*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

1922 Burial Permit Clerk.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Eronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Apoplectic.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61146

D 61146

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 23157 Charles ST. 17 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME.

(a) RESIDENCE No. 23157 Charles ST. WARD

(Usual place of abode)

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth 10 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 6/1854

7 AGE Years 68 Months 2 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant (Address) This Matthew Whiteful 2313 N. Charles

15

Filed 19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1922

17 I HEREBY CERTIFY, That I attended deceased from 1918 to 1922

that I last saw him alive on January 8 1922

and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH\* was as follows:

Cerebral softening following apoplexy.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis

(Signed) George M. Frye, M. D.

Address 2435 Maryland Ave.

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL (Cremation or Removal) Delta Ry

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

William Beck 502 E. North Ave.

tion should be carefully supplied. Note must be made of the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Settle 2435 Mel Ave.

N.B.—Every item of information furnished is very important. See instructions on back of certificate.

Levi Lentz  
HEALTH DEPARTMENT—CITY OF BALTIMORE  
D 61147 X 167 D 61147  
CERTIFICATE OF DEATH.

1-PLACE OF DEATH  
CITY OF BALTIMORE (No. 1418 E. Biddle ST. 90 WARD)  
2-FULL NAME Levi Lentz  
(Residence in Baltimore: No. 1418 E. Biddle St.; yrs., mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male	4-COLOR OR RACE White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married
6-DATE OF BIRTH, (Month) (Day) (Year) 1877		
7-AGE, 50 yrs. mos. da. If LESS than 1 day, ...hrs. or...min.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE, (State or Country). York Pa.		
PARENTS.	10-NAME OF FATHER Unknown	
	11-BIRTHPLACE OF FATHER (State or Country). Unknown	
	12-MAIDEN NAME OF MOTHER Unknown	
	13-BIRTHPLACE OF MOTHER (State or Country). Unknown	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) Mr. Hall  
(Address) 1418 E. Biddle St.

15-FEB 10 1922 ROBERT R. KRAUTER,  
Filed... 191... Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,  
(Month) (Day) (Year)  
Feb 8, 1912

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an...  
(Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said...  
(Inquest, autopsy or inquiry.)  
and that said deceased came to... death  
on the day stated above.  
The CAUSE OF DEATH was as follows:  
Suicide by self-hanging  
Gas  
(Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY  
(Secondary)  
(Signed) ...  
(Coroner)  
2-9-32 (Address) ...

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).  
At place of death... yrs. ... mos. ... da. State... yrs. ... mos. ... da.  
Where was disease contracted, if not at place of death?  
Former or usual residence...

PLACE OF BURIAL OR REMOVAL, York Pa.  
DATE OF BURIAL, Feb 10, 1922  
UNDERTAKER, E. A. Wiedefeld  
ADDRESS, 521 E 22 St.

## HEALTH DEPARTMENT--CITY OF BALTIMORE

D 61148

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *Greenfield* ST., *Keene Ave.* WARD)

## 2-FULL NAME

(a) RESIDENCE NO. *Greenfield* ST., *Keene Ave.* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *61* yrs. *11* mos. *15* ds.How long in U. S., if of foreign birth *2* yrs. *1* mos. *1* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced, give name of HUSBAND or (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *February 9* 19 *22*

17 I HEREBY CERTIFY, That I attended deceased from

*Nov. 12*, 19 *21*, to *Feb. 9*, 19 *22*.that I last saw him alive on *Feb. 8*, 19 *22*.and that death occurred, on the date stated above, at *2:30* a. m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma of breast.*

CONTRIBUTORY (Secondary)

(duration) *1* yrs. *4* mos. *4* ds.(duration) *3* yrs. *3* mos. *4* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *Feb. 9*Was there an autopsy? *No*What test confirmed diagnosis *Blind* (Signed) *A. M. Bacon*, M. D.9, 19 *22* (Address) *Parkville Md.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

*Green Cemetery* *Aberdeen, Md.*

20 UNDERTAKER

*Henry Hawk Son*

DATE OF BURIAL

*Feb 11* 19 *22*

ADDRESS

*1301 E Egan St*

Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. TION is very important.

N.B.—Every item of information should be carefully classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61149

## CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 1821 S. Modersau St.)

FULL NAME

(Residence in Baltimore: No. 1821 S. Modersau St.; yrs., mos., ds.)

1821 S. Modersau St.  
Paris Janodski  
1821 S. Modersau

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word)

Single

6-DATE OF BIRTH.

Aug 25, 1918

7-AGE.

3 yrs., 5 mos., 14 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FEB 10 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Feb 8, 1922

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

acute tubercular pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) (Coroner)

2 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Holy Redeemer Cemetery, February 11, 1922

20-UNDERTAKER, ADDRESS

Henry Hock Sun, 1301 E. Eager St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61150

D 61150

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 N. Luzerne Ave. ST., 7 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME Joseph Zeidler

(a) RESIDENCE NO. 507 N. Luzerne Ave. ST., 7 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Zeidler

6 DATE OF BIRTH (month, day, and year) Feb 7 1853

7 AGE Years 69 Months 0 Days 0 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Margaret Command (Address) 507 N. Luzerne Ave.

FEB 10 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6th, 1922,

that I last saw him alive on Feb. 6th, 1922,

and that death occurred, on the date stated above, at 10 A. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Throat.

CONTRIBUTORY (Secondary) Throat, (duration) 3 yrs. 3 mos. ds. about 22 hrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. W. S. Seymour, M. D. (Address) 2528 E. Monument St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mount Carmel Cem.

DATE OF BURIAL

Feb. 10 1922

20 UNDERTAKER

H. Sander Saus

ADDRESS

1710 Reed St.

nation through the Cemetery Department. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61151

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1513 Rutland Ave. ST.,

WARD)

## 2-FULL NAME

Gustav E. E. Zabel

(a) RESIDENCE NO. 1513 Rutland Ave. ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

6a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Johanna Zabel, 50

6 DATE OF BIRTH (month, day, and year) Aug. 17-1879

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

71 6 1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Kiel (State or country) Germany

10 NAME OF FATHER William Zabel

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14 Informant Johanna Zabel (Address) 1513 Rutland Ave.

15 FEB 10 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8 1922

17 I HEREBY CERTIFY that I attended deceased from Jan. 22, 1922, to Feb. 8, 1922.

that I last saw him alive on Feb. 7, 1922, and that death occurred, on the date stated above, at 12 30 P.m.

The CAUSE OF DEATH\* was as follows:

Diffuse Bronchitis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. S. Sander, M. D.

(Address) 1504 E. Pratt St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park Cem.

20 UNDERTAKER

H. Sander Sons

DATE OF BURIAL

Feb. 10 1922

ADDRESS

1765 Reister

Exact statement of OCCUPATION should be carefully stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61152

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1157 Monticore ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. 1157 Monticore ST.: 21 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) May 7, 1921

7 AGE Years 9 Months 3 Days 3 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.10 NAME OF FATHER Joseph J. Henry11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.12 MAIDEN NAME OF MOTHER Kate Schwenner13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14

Informant

(Address) 1157 Monticore

15

FEB 10 1922

ROBERT K. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-10-1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 9 to Feb 10, 1922, that I last saw him alive on Feb 10, 1922, and that death occurred, on the date stated above, at 29 m. The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. L. Damm

M. D.

19 (Address) 1157 Monticore

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Western Cemetery Feb 11 1922  
Chas. L. Little 2900  
Edmondson

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61153

## CERTIFICATE OF DEATH.

D 61153

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *209 E 33rd*)ST.: *12* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Frances Madeleine Wentz*(a) RESIDENCE. NO. *209 E 33rd*ST.: *12* WARD. *Resident*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *83* yrs. *11* mos. *5* ds. How long in U. S., if of foreign birth? *83* yrs. *11* mos. *5* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed,

or Divorced (write the word)

*widow*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Henry Day Wentz*

6 DATE OF BIRTH (month, day, and year)

*3-4-1838*

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*83**11**5*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

*None*

(c) Name of employer

*None*9 BIRTHPLACE (city or town),  
(State or country)*Balto, Md.*

10 NAME OF FATHER

*Chas Albert Eutz*

11 BIRTHPLACE OF FATHER (city or town)

*Wiedenburg Germany*

(State or country)

12 MAIDEN NAME OF MOTHER

*Susanna Jackson*

13 BIRTHPLACE OF MOTHER (city or town)

*Wye Mills Talbot Co. Md.*

(State or country)

14

Informant  
(Address)*Mrs. Frances Turner, daughter  
209 E 33rd St.*

15

Filed

*FEB 10 1922**J. E. Rehm*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 9 - 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*May 1, 1919* to *July 9, 1922*that I last saw her alive on *July 9* at *12:40 A. M.*

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

*3rd attack of Paralysis, old age**4 years* (duration) yrs. mos. ds.CONTRIBUTORY *General Wrecking*  
(Secondary) *1 year* (duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? *Bradock Heights, Md.*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Infection; Leptospira*(Signed) *John Turner* M. D., 19 (Address) *1914 N. Charles St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Louden Park*

DATE OF BURIAL

*July 11, 1922*

20 UNDERTAKER

*Stewart & Mawry*

ADDRESS

*108 W. No. Ave.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Probably apoplectic.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61154

D 61154

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt. Vernon & Cedar Aves. ST. 13 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JANE PADDINGTON HAYEN(a) RESIDENCE. No. Mt. Vernon-Cedar Aves. ST. 13 WARD. (Resident)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 80 yrs. ? mos. ? ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofEBERHARD HAYEN6 DATE OF BIRTH (month, day, and year) March-3-1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
83	10	18		

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

None

9 BIRTHPLACE (city or town) Isle of St. Kitts  
(State or country) West Indies10 NAME OF FATHER Edward Paddington11 BIRTHPLACE OF FATHER (city or town) Brighton  
(State or country) England12 MAIDEN NAME OF MOTHER Isabella Boyd13 BIRTHPLACE OF MOTHER (city or town) Dublin  
(State or country) Ireland14 Informant The Misses Hayen, (daughters)  
(Address) Mt. Vernon-Cedar Aves, City.15 Filed FEB 10 1922 J. M. M. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 19 2217 I HEREBY CERTIFY, That I attended deceased from abt 1910 to Feb 10 19 22.that I last saw him alive on Feb 9 19 22.and that death occurred, on the date stated above, at 12:55 A.M.

The CAUSE OF DEATH\* was as follows:

Accidental fall down steps  
at 6 A.M. Feb. 8-22CONTRIBUTORY  
(Secondary)Central hemorrhage  
(duration) yrs. mos. 19 hrs18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date of ✓Was there an autopsy? noWhat test confirmed diagnosis? unconsciousness  
bruises cuts about head  
(Signed) Dr. M. D.  
(Address) 1025 Madison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Loudon Park Cemetery

DATE OF BURIAL

Feb-13-22

20 UNDERTAKER

STEWART & MOWEN COMPANY  
(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61155

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 827 A. Bond

ST.: 7 WARD)

## 2-FULL NAME

Mary J. Williams

## (a) RESIDENCE

No. 827 A. Bond

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Williams

6 DATE OF BIRTH (month, day, and year) Nov 19 1866

7 AGE Years 55 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundry 041

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

10 NAME OF FATHER Henry Wright

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant Mrs. Mary Jackson (Address) 827 A. Bond St

15 REGISTRATION ROBERT R. KRAUTER Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-8-1922

17 I HEREBY CERTIFY, That I attended deceased from

Feb 5, 1922, to Feb 8, 1922,

that I last saw her alive on Feb 7, 1922,

and that death occurred, on the date stated above, at 5:30 A. M.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Erysipelas

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas, M. D.

2-8, 1922 Address 822 A. Bond St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Zion Cemetery

Feb 12 1922

20 UNDERTAKER

ADDRESS

R. Cross 1405 Meriden

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

D 61156 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61156

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 17 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Neal(a) RESIDENCE. NO. 674 Bradley st.ST. 17 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
----------------------	-----------------------------------	---

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	<u>38</u>			

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town)  
(State or country)Virginia10 NAME OF FATHER Solomon Neal11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Virginia12 MAIDEN NAME OF MOTHER Fannie Prayor13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Virginia14 Informant Hospital Records  
(Address) M.T.H.15 FEB 10 1922 ROBERT R. KRAUTER  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6, 1922

17 I HEREBY CERTIFY, That I attended deceased from  
Jan. 26, 1922, to Feb. 6, 1922,  
that I last saw him alive on Feb. 6, 1922,  
and that death occurred, on the date stated above, at 11.55 p.m.  
The CAUSE OF DEATH\* was as follows:

Chronic Miliary Tuberculosis(duration) yrs. 9 mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? UnknownDid an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis L. Dabaglian M. D.2-7-22 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount AuburnFeb 10 1922

20 UNDERTAKER

ADDRESS

W. E. Gross 1605 Maryland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupation of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Lungs involved*

D 61157 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Providence Hospital* WARD)

## 2. FULL NAME

*Bea Bessie Beames*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

*1618 McCulloch St.*

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*Black*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Unknown*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*2 4 yrs*

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

*Bookkeeper*

## (b) General nature of industry, business, or establishment in which employed (or employer)

*1008*

## (c) Name of employer

*Wm. B. B. Co. Danville, Virginia*

## 10 NAME OF FATHER

*William Beames*

## 11 BIRTHPLACE OF FATHER (city or town)

*VA*

(State or country)

## 12 MAIDEN NAME OF MOTHER

*Mary E. Wilson*

## 13 BIRTHPLACE OF MOTHER (city or town)

*VA*

(State or country)

## 14

Informant (Address)

*Samuel Beames, (Brother) Danville, Virginia*

## 15

Filed

FEB 10 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*Feb 9th 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from *Jan 28th 1922* to *Feb 9 1922*, that I last saw her alive on *Feb 9th 1922*, and that death occurred, on the date stated above, at *6:30 p.m.*

## The CAUSE OF DEATH\* was as follows:

*Pneumonia*(duration) *1* yrs. *1* mos. *2* ds.

## CONTRIBUTORY

(Secondary)

*Acute congestion of the lungs*(duration) *1* yrs. *1* mos. *20* ds.

## 18 Where was disease contracted if not at place of death?

*VA*

## Did an operation precede death?

*No*

Date of

## Was there an autopsy?

*No*

## What test confirmed diagnosis?

*Physical Exam*

(Signed)

*Edith Hall*

M. D.

19

(Address)

*426 E. 2nd St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Danville VA*

## DATE OF BURIAL

*Feb 10 1922*

## 20 UNDERTAKER

*Mrs Robert A. Elliott*

## ADDRESS

*1725 Ashland St.*

Exact statement of OCCUPATION. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61158

D 61158

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 N PortST.: 7

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gene Platak(a) RESIDENCE. NO. 712 N Port

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 24 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced (write the word) at school

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 15 1917

7 AGE

Years 14Months 1Days 24

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at school

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt10 NAME OF FATHER Joseph Platak

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Croatia12 MAIDEN NAME OF MOTHER Rosalie Borkova

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Croatia

14

Informant. Joseph Platak  
(Address) 712 N Port

15

FEB 10 1922

ROBERT A. KRAUTER  
Registrar

Bureau Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan. 20 - 1922, to Feb 8 - 1922, that I last saw him alive on Feb 8 - 1922.and that death occurred, on the date stated above, at 7 4 m.

The CAUSE OF DEATH\* was as follows:

Cerebral Tuberculosis - Heart Disease(duration) 1 yrs. 2 mos. 24 ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. 2 mos. 24 ds.18 Where was disease contracted if not at place of death? noDid an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? none(Signed) Robert A. Krauter M. D.10/21/1922 Address) 1257 N Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy RedeemerFeb 11 1922

20 UNDERTAKER

ADDRESS

Emt Cracker1066 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

D 61159

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61159

## CERTIFICATE OF DEATH.

31

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2931 Pennsylvania Ave 13 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Charles G. Miller

## (a) RESIDENCE NO.

2931 Pennsylvania Ave

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Divorced

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Divorced

## 6 DATE OF BIRTH (month, day, and year)

Dec. 1<sup>st</sup> 1871

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5027

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Type setter

(b) General nature of industry, business, or establishment in which employed (or employer)

Newspaper work

(c) Name of employer

Batts. News

## 9 BIRTHPLACE (city or town) (State or country)

Portsmouth, Pa.

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

## 14

Informant (Address)

Mr. Grace T. Jones  
2931 Pennsylvania Ave

## 15

FEB 10 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb. 8, 1922

## 17

I HEREBY CERTIFY, That I attended deceased from Feb 4, 1922 to Feb 8, 1922that I last saw him alive on Feb 8, 1922and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia (Tubercular)

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Evans, M. D.(Address) 642 W. Madison

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park Cem

## UNDERTAKER

Wm. J. Suckner & Son

## DATE OF BURIAL

Feb 11, 1922

## ADDRESS

N.Y.C.

Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61160

## CERTIFICATE OF DEATH.

D 61160

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1705 W. Lexington St. ST., 19 WARD)

## 2. FULL NAME

Eliza Jane Shure

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1705 W. Lexington St. ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 3 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced  
HUSBAND of  
or) WIFE of

Job Shure

6 DATE OF BIRTH (month, day, and year) Oct. 12<sup>th</sup> 18457 AGE Years Months Days If LESS than 1 day, hrs. or min.  
76 3 27

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Md.

10 NAME OF FATHER John Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Unknown14 Informant Job Shure  
(Address) 1705 W. Lexington St.

15 FEB 10 1922 ROBERT R. KRAUTER

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8<sup>th</sup> 192217 I HEREBY CERTIFY, That I attended deceased from Dec 25<sup>th</sup> 1921 to Feb 8<sup>th</sup> 1922, that I last saw her alive on Feb 7<sup>th</sup> 1922, and that death occurred, on the date stated above, at 1 A. m.  
The CAUSE OF DEATH\* was as follows:

Carcinoma of the Bladder

(duration) yrs. 2 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D. M. D. Feb. 8<sup>th</sup> 1922 (Address) 108 N. Putnam Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Baltimore Cemetery Feb. 10<sup>th</sup> 1922

20 UNDERTAKER

ADDRESS

Graph B Cook 103 N. Putnam Ave

Information should be carefully supplied. Exact statement of OCCUPATION, CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61161

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No.

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ST. 13 WARD

ST. WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

FEB 10 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted If not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61162

D 61162

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

2402 Elsinor Ave.

ST. 15

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME Mary Fountain Elliott

(a) RESIDENCE. No. 2402 Elsinor Ave

ST.

WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Charles H. Elliott

June 30th, 1857

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

64

7

9

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town; State or country) Denton

10 NAME OF FATHER James Fountain Elliott

11 BIRTHPLACE OF FATHER (city or town; State or country)

12 MAIDEN NAME OF MOTHER Ellen Fountain Elliott

13 BIRTHPLACE OF MOTHER (city or town; State or country)

14

Informant (Address)

Howard H. Elliott

2402 Elsinor Ave.

15 Filed

Robert P. Harrison Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/9 1922

17 I HEREBY CERTIFY, That I attended deceased from 2/4 1922, to 2/9 1922, that I last saw him alive on 2/9 1922, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Pulmonary Aneurysm

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

2/10/1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Loudon Park Cemetery

Feb 11th, 1922

20 UNDERTAKER

Buttram &amp; Co

ADDRESS

1123 N. E. Ave.

8 10 1922

D 61163 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61163

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2340 Frederick St., 20 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David S. Muddiman

(Residence in Baltimore: No. 2340 Frederick St.; yrs., 7 mos., 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, white 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, July 18, 1921 (Month) (Day) (Year)

7-AGE, 6 yrs., 24 mos., 7 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, Grover C. Muddiman

11-BIRTHPLACE OF FATHER, (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Olive Herndon

13-BIRTHPLACE OF MOTHER, (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Grover C. Muddiman

(Address), 2340 Frederick St.

15- Robert P. Harrison, Registrar.

101922 Digital Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 9, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows: Lobal Pneumonia

(Duration) yrs., mos., ds. CONTRIBUTORY (Secondary) acute bronchitis

(Signed) James M. Denton, M.D. (Coroner) Feb. 9, 1922 (Address) 700 E. Chase St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Northland Cemetery Feb. 11, 1922

20-UNDERTAKER, ADDRESS

J.B. Sheppard 2236 Fredk St



D 61164

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 61164

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3768 Morley Ave.* ST. *70* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *3768 Morley Ave*St.; *55* yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

## 6-DATE OF BIRTH,

*Aug 2nd*, 18*36*  
(Month) (Day) (Year)

## 7-AGE,

*85* yrs. *6* mos. *7* ds.

If LESS than 1 day, ....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Cabinetmaker*  
*014*

## 9-BIRTHPLACE, (State or Country),

*Germany*

## 10-NAME OF FATHER,

*Frank Fischer*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Germany*

## 12-MAIDEN NAME OF MOTHER

*Don't know*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Germany*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Agnes Sogler*(Address) *3768 Morley Ave*

## 15-

Filed

*Robert P. Harrison,*

Registrar.

EB 101922 Serial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Feb*, 19*22*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Feb. 8*, 19*22*, to *Feb. 9*, 19*22*,that I saw him alive on *Feb 9*, 19*22*, 19*22*,and that death occurred, on the date stated above, at *5 P.* m.

The CAUSE OF DEATH\* was as follows:

*Seminality - Asthma*(Duration) *2* yrs. mos. ds.

## CONTRIBUTORY (Secondary)

*Cardiac Failure*(Signed) *Howard M. Buber* M. D.*2-9-22*, 19*22* (Address) *1100 W. Lafayette St. E*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*St. Mary's Cemetery**Feb. 10, 1922*

## 20-UNDERTAKER

## ADDRESS

*Clark & Thomas**1100 W. Lafayette St. E*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61165

D 61165

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 Columbia ave. 27 ST. 27 WARD)2. FULL NAME Margaret A. Fletcher(a) RESIDENCE NO. 628 Columbia ave ST. 27 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) widowed5a If married, widowed, or divorced  
HUSBAND of John H. Fletcher  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) January 18617 AGE 60 Years Months Days If LESS than 1 day, 0 hrs. or 0 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Knoxville,  
(State or country) Tenn.10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Tenn.  
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Tenn.  
(State or country)14 Informant Clarence H. Fletcher  
(Address) 628 Columbia ave.15 Robert P. Harrison  
Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 192217 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1922, to Feb 10, 1922.that I last saw him alive on Feb 9, 1922.and that death occurred, on the date stated above, at 5:45 A. m.

The CAUSE OF DEATH\* was as follows:

Lobar PneumoniaCONTRIBUTORY (Secondary) Pulmonary Tuberculosis  
(duration) 7 yrs. 0 mos. 0 ds.  
(duration) 6 yrs. 0 mos. 0 ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date of -Was there an autopsy? noWhat test confirmed diagnosis? clinical(Signed) Samuel H. H. H., M. D.7/10/22 (Address) 2798 Columbia ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Mt. Olivet DATE OF BURIAL Feb. 13, 1922  
ADDRESS20 UNDERTAKER Wm. Cook, 502 E. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of place of death. See instructions on back of certificates. TION is very important.

D 61166 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61166

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3296 Lafayette Ave. WARD)

## 2-FULL NAME

(a) RESIDENCE No. 3296 Lafayette Ave.

(Usual place of abode)

WARD

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 4 mos. ds. How long in U. S., if of foreign birth 10 mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Robert P. Harrison,

Registrar

Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY That I attended deceased from

July 15, 1921, to Feb. 9, 1922.

that I last saw him alive on Feb. 5, 1922.

and that death occurred, on the date stated above, at 3:20 p.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis - (duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 6 mos. ds.

18 Where was disease contracted? if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Tuberculin

(Signed) Robert P. Harrison, M. D.

Feb. 10 1922 (Address) 2111 Maryland Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE

DATE OF BURIAL

Elkton Md Feb 12 1922

ADDRESS

William C. 502 E. North

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61167

D 61167

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 Orleans ST., 5 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Robert McManus

## (a) RESIDENCE NO.

1111 Orleans St ST.,

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life time yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of

(or) WidowedJennie McManus

## 6 DATE OF BIRTH (month, day, and year)

Don't know 1849

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.73

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labourer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Ind

## 10 NAME OF FATHER

Don't know

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Don't know

## 12 MAIDEN NAME OF MOTHER

Don't know

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Don't know

## 14

Informant  
(Address)Jennie McManus

## 15

Informant  
(Address)Don't know

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb 9/21/22

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan 14, 1922, to Feb 6, 1922,that I last saw him alive on Feb 6, 1922,and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

chronic myocarditis(duration) yrs. 7 mos. ds.

## CONTRIBUTORY (Secondary)

Cerebral Hemorrhage(duration) yrs. 1 mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? Physical(Signed) A. L. Hornstein, M. D.2/10, 1922 (Address) 733 Aspinth St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Western Burial - Feb 13/22

## 20 UNDERTAKER

## ADDRESS

Wm Cook 5026 North

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE D 61168

D 61168

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 25 76 Rose ST. 6 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. 25 76 Rose

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ST.

WARD.

(If nonresident give city or town and State)

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M.* 4 COLOR OR RACE *M.* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Christian Krueger*6 DATE OF BIRTH (month, day, and year) *Dec 23 1850*7 AGE *66* Years *1* Months *16* Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer 040*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Germany* (State or country)10 NAME OF FATHER *Not known*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Not known*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)

14

Informant (Address) *Mr. Chas. Krueger 25 76 Rose St.*

15

Filed

*Robert P. Harrison*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 9, 1922*17 I HEREBY CERTIFY, That I attended deceased from *Feb 1, 1922* to *Feb 9, 1922*that I last saw him alive on *Feb 9, 1922*and that death occurred, on the date stated above, at *6 P. M.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Colon*  
*Sigmoid*  
(duration) *2* yrs. *2* mos. *0* ds.

CONTRIBUTORY (Secondary)

(duration) *—* yrs. *—* mos. *—* ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *None*(Signed) *Frank A. ...* M. D.(Address) *928 ...*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Trinity Cemetery**2/11 1922*

20 UNDERTAKER

ADDRESS

*John A. Moran 3090 E. Balto. St.*

Information should be carefully supplied. Your statement of cause of death in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

B 101922 Burial Permit *101922*

D 61169

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61169

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *Maryland General Hospital* ST. *11* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Maggie Stoner*(a) RESIDENCE. NO. *Westminster Md*

(Usual place of abode)

ST.

WARD. *Westminster, Md.*

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *11* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of *James Stoner*  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *May 9, 1871*7 AGE Years *51* Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Ohio*10 NAME OF FATHER *David Boyer*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Penn.*12 MAIDEN NAME OF MOTHER *Elizabeth Cable*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ohio*14 Informant *S. C. S. Cover*(Address) *Westminster Md*15 Filed *19*

Robert P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 11* 1922

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 6*, 1922, to *Feb 11*, 1922,that I last saw him alive on *Feb 11*, 1922,and that death occurred, on the date stated above, at *5:20 a.m.*

The CAUSE OF DEATH\* was as follows:

*Operation for Retroverted & Prolapsed Uterus & Relaxed Vaginae Ovaries*  
(duration) *7* yrs. *4* mos. *4* ds.

CONTRIBUTORY (Secondary)

*Arterial Insufficiency*  
(duration) *11* yrs. *4* mos. *4* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *Feb 7, 1922*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical Symptoms*(Signed) *Geo. H. Wising*, M. D., 19 (Address) *Maryland General Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Westminster Cemetery**Feb 14* 19

20 UNDERTAKER

ADDRESS

*H.B. Archard & Son**Westminster*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

B1 1922

Burial Permit Blank

D 61170 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61170

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 Stanford Ave ST. 10 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice E. Capps

(a) RESIDENCE. No. 704 Stanford Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Capps

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 74 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant: Wm. P. Nixon

(Address) 704 Stanford Ave

15 Filed 1922 19 Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-8-1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1922, to Feb 8, 1922, that I last saw her alive on Feb 7, 1922, and that death occurred, on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH\* was as follows:

Chronic heart disease

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas, M. D.

2-10-1922 Address) 822 N. Bond St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

David Bern

Feb 11 1922

20 UNDERTAKER

ADDRESS

Jas. M. Skimmer 1625 E. Mad St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

B 11 1922

D 61171

Spec.—6-9-19—H. P. Co.—1000 Bks.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61171

161-002

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 735 Ajax Alley ST. 10 WARD)

## 2-FULL NAME

Bernice Rogers

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE. NO.

735 Ajax Alley

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 1 mos. 1 ds.

How long in U. S., if of foreign birth?

yrs. 1 mos. 1 ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

Col

## 5 Single, Married, Widowed, or Divorced (write the word)

single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Feb. 3 - 1922

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

## 10 NAME OF FATHER

Clarence Rogers

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore, Md.

## 12 MAIDEN NAME OF MOTHER

Bertie Anderson

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md.

## 14

Informant (Address)

Bertie Rogers  
735 Ajax Alley

## 15

Robert J. Harrison

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb. 10 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb. 9 1922, to Feb. 9 1922,that I last saw her alive on Feb. 9 1922,and that death occurred, on the date stated above, at 8:40 a.m.

The CAUSE OF DEATH\* was as follows:

Birth Injury (Brain hemorrhage)(duration) yrs. 7 mos. 7 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. none mos. none ds. none

## 18 Where was disease contracted

if not at place of death? HomeDid an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Horace G. Stewart, M. D.(Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Lanier Cemetery Feb. 11 22

## 20 UNDERTAKER

## ADDRESS

Oliver H. Johnson 467 N. Carroll

Cause of Death in plain terms, so that it may be properly classified. Exact statement of occupation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation should be carefully supplied. See instructions on back of certificates.

1022



D 61172 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61172

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 E. Eager ST., 7 WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

19a Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

B 11 1922

Burial Permit Clerk.

61173 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61173

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Henry Loent

## (a) RESIDENCE. NO.

1307 Division St.

ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

30 years

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Black

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

March 4<sup>th</sup> 1853

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

69

11

5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Wiater 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Maryland

## 10 NAME OF FATHER

John Loent

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Courtney Leath

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

## 14

Informant (Address)

## 15

Filed

Robert P. Harrison;

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb 9<sup>th</sup> 1922

## 17

I HEREBY CERTIFY, That I attended, deceased from Feb 1<sup>st</sup> 1922, to Feb 9<sup>th</sup> 1922,that I last saw him alive on Feb 9<sup>th</sup> 1922,

and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH\* was as follows:

Myocardial insufficiency

(duration) yrs. 5 mos. da.

## CONTRIBUTORY

(Secondary)

Arteriosclerosis (hypertension)

(duration) yrs. 10 mos. da.

## 18 Where was disease contracted

If not at place of death?

Home

## Did an operation precede death?

No

Date of

## Was there an autopsy?

Yes

## What test confirmed diagnosis?

None

(Signed)

Francis R. Dieulaide, M. D.

Feb. 9

1922 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Auburn Cemetery

## DATE OF BURIAL

Feb. 11 1922

## 20 UNDERTAKER

Geo. M. Johnson

## ADDRESS

1234 E. St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

811 1922

D 61174

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61174

## CERTIFICATE OF DEATH.

197

## PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (NO. *Johns Hopkins Hospital*)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

*Albert Beasley*(Residence in Baltimore: No. *331 Oxford St.*)St. *3* yrs., mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

*Male*

4-COLOR OR RACE,

*Col.*

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

*Single*

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

*1/8/89*

7-AGE,

*33*

yrs.

mos.

da.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*887*

9-BIRTHPLACE,

(State or Country),

*NA*

10-NAME OF FATHER,

*Out known*

11-BIRTHPLACE OF FATHER,

(State or Country)

*Out known*

12-MAIDEN NAME OF MOTHER

*Out known*

13-BIRTHPLACE OF MOTHER,

(State or Country),

*Out known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Daniel Easton*

(Address)

*916 Pa ave*

15-

*Robert P. Harrison,*

Filed

191

*Marial Permit Clerk*

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH,

*Feb 6*

(Month)

*1913*

(Day)

*1913*

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereof and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.)and that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Homicide by pistol**1st* (Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

*1st* (Duration) yrs. mos. da.(Signed) *W. J. Miller* M. D.191... (Address) *916 Pa ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. mos. da. State... yrs. mos. da.

Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Ambrose**Feb 11, 1913*

20-UNDERTAKER

*Daniel Easton*

ADDRESS

*916 Pa ave*

Every item of information should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

841 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61175

D 61175

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Sq. Hopkins* 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *210 N Mont St* St.; *50* yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*M*

4-COLOR OR RACE,

*Col*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH,

*unknown*, *1970*  
(Month) (Day) (Year)

7-AGE,

*52**52*

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Laborer**040*

9-BIRTHPLACE,

(State or Country), *D.C. Md.*

10-NAME OF FATHER,

*unknown*

11-BIRTHPLACE OF FATHER

(State or Country), *unknown*

12-MAIDEN NAME OF MOTHER

*unknown*

13-BIRTHPLACE OF MOTHER

(State or Country), *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Hospital Records*

(Address) .....

15-

Filed

*Robert P. Harrison,*

191

Registrar.

*1922* *Death Permit Clerk.*

## MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Jan-30* 19*22*, to *Feb 8* 19*22*that I saw him alive on *Feb 8* 19*22*,and that death occurred, on the date stated above, at *7 A.* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Interstitial Nephritis*(Duration) *3* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) *2* yrs. mos. ds.(Signed) *Walter J. Parr* M. D.191... (Address) *Franklin Sq. Hopkins*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *9* yrs. mos. ds. in the *MD* State *9* yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *302 Parrish*

19-PLACE OF BURIAL OR REMOVAL,

*Mont Auburn*

DATE OF BURIAL,

*Feb 12*, 19*22*

20-UNDERTAKER

*John H Owens*

ADDRESS

*539 Balch St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.



D 61176 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61176

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2204 Callow Ave. ST. 12 WARD)

## 2-FULL NAME

(a) RESIDENCE. NO. 2204 Callow Ave. ST. 12 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 07 yrs. — mos. — ds.

How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (Write the word)

Married

5a If married, widowed, or divorced,

HUSBAND of

(or) WIFE of

Helenista Pines

6 DATE OF BIRTH (month, day, and year)

Jan. 16<sup>th</sup> 1853

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

69

+

24

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Jewelry

(b) General nature of industry, business, or establishment in which employed (or employer)

Mfg.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Germany

10 NAME OF FATHER

Henry Lewis Pines

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant

(Address)

J. Pines  
2204 Callow Ave.

15

Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 10<sup>th</sup> 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 1<sup>st</sup> 1922, to Feb. 9<sup>th</sup> 1922,that I last saw him alive on Feb. 9<sup>th</sup> 1922,

and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH\* was as follows:

Chronic Lung Nephritis

(duration) 4 yrs. 4 mos. 1 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

19

(Address)

1920 Linden Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Heaven Friendship

Feb. 12<sup>th</sup> 1922

20 UNDERTAKER

ADDRESS

David Soudheim

118 W. 11th St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B 11 1922 Burial Permit Clerk

D 61177

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61177

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1232 Battery Ave. St. 24 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....Franziska Dellman.

(Residence in Baltimore: No. 1232 Battery Ave. 65 St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, November 3rd, 1886. (Month) (Day) (Year)

7-AGE, 85 yrs. 3 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Germany.

10-NAME OF FATHER, Bauer.

11-BIRTHPLACE OF FATHER, (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry C. Dellman, (son)

(Address) 1232 Battery Ave.

15- Robert F. Harrison, Registrar.

1922 Burial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 3th, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage.  
Arterio-sclerosis.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Feb, 9th 1922 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

London Park Feb 13, 1922

20-UNDERTAKER, ADDRESS, F. &amp; B. Harle 115 E. West St.

D 61178 HEALTH DEPARTMENT—CITY OF BALTIMORE 61178

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 N Lakewood ST., 6 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

87 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Burial Permit Clerk

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 8 1922 to Feb 9 1922

that I last saw her alive on Feb 9 1922 and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Meyer, Jr., M. D. (Address) 2638 E. Baltimore St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No hemorrhage. Not apoplectic.*  
*No chronic heart disease.*



D 61179

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61179

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *9 S Carey -*ST.: *18* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Curry & Glover (Glover)*(a) RESIDENCE. No. *9 S Carey -*ST.: *18* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*female White married*

5a If married, widowed, or divorced

*HUSBAND of Marion Glover*  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *May 7/1888*

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*66*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*At Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

*137*

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md.*  
(State or country)10 NAME OF FATHER *Edmund Hall*

PARENTS

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Md.*12 MAIDEN NAME OF MOTHER *Euneline Daugherty*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Md.*

14

Informant *Marion Glover*  
(Address) *9 S Carey St.*

15

Filed *Robert P. Harrison,*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/9* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

*2/7/22*, 19 *22*, to *2/9/22*, 19 *22*.that I last saw him alive on *2/9/22*, 19 *22*.and that death occurred, on the date stated above, at *10:25 p.m.*

The CAUSE OF DEATH\* was as follows:

*Cardiac failure*(duration) yrs. mos. *2* ds.CONTRIBUTORY *Hypertension*  
(Secondary)(duration) yrs. mos. *2* ds.18 Where was disease contracted  
if not at place of death? *at place of death*Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *No*(Signed) *R. P. Harrison*

M. D.

1922 (Address) *1302 N. Graham*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Not Buried -**Feb 13 1922*

20 UNDERTAKER

ADDRESS

*Wm. Cook 5026 E. North Ave.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 11 1922

Burial Permit Clerk

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as *fracture of skull*, and *consequences* (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Apoplectic.*

*2/10 Mayland*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61180

D 61180

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4205 Springdale Ave. ST. 28 WARD)

2-FULL NAME Virginia L. Kahl

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 4205 Springdale Ave. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Edward H. Kahl

6 DATE OF BIRTH (month, day, and year) Oct. 15<sup>th</sup> 1880

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

41 3 24

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harford County Md. (State or country)

10 NAME OF FATHER John Gorrell

11 BIRTHPLACE OF FATHER (city or town) Harford Co. Md. (State or country)

12 MAIDEN NAME OF MOTHER Sophia Ann Bowman

13 BIRTHPLACE OF MOTHER (city or town) Harford Co. Md. (State or country)

14 Informant Edward H. Kahl (Address) 4205 Springdale Ave.

15 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8<sup>th</sup> 19 2217 I HEREBY CERTIFY, That I attended deceased from Feb. 8<sup>th</sup> 1922 to Feb. 8<sup>th</sup> 1922.that I last saw her alive on Feb. 8<sup>th</sup> 1922, and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic interstitial nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? I do not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? urinalysis and cystoscopy

(Signed) J. H. Stenwell, M. D.

Feb. 9<sup>th</sup> 1922 (Address) 2226 Madison Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park Cemetery

20 UNDERTAKER

Joseph B. Cook

DATE OF BURIAL

Feb. 11<sup>th</sup> 1922

ADDRESS

1003 A Belair St

Information should be carefully supplied. Exact statement of OCCASION OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

EB 11 1922

D 61181 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61181

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *Mercy Hospital* ST. *4* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Alice Scott*

## (a) RESIDENCE. NO.

*306 Hargrove Alley* ST. *4* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *2* yrs. *10* mos. *15* ds. How long in U. S., if of foreign birth? *2* yrs. *10* mos. *15* ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female Colored*

## 4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Single*

## 6 DATE OF BIRTH (month, day, and year)

*(?) 1849*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*72?*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

*None*

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*lives in Balt-city 48 years*

## 10 NAME OF FATHER

*James Scott*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*and*

## 12 MAIDEN NAME OF MOTHER

*Unknown*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Unknown*

## 14

Informant (Address)

*Mercy Hospital Record*

## 15

Filed

*Robert F. Harrison,*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 9, 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from *Jan 30, 1922*, to *Feb 9, 1922*.that I last saw her alive on *Feb. 9, 1922*and that death occurred, on the date stated above, at *3:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Senility and malnutrition*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*Home*Did an operation precede death? *no* Date ofWas there an autopsy? *yes*

What test confirmed diagnosis?

(Signed) *John J. Gault*, M. D., 19 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Laurel Cemetery**Feb. 11, 1922*

## 20 UNDERTAKER

*Mrs Robert A Elliott*

## ADDRESS

*1725 Ashland Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1922 Burial Permit Clerk.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61182

## CERTIFICATE OF DEATH.

D 61182

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 23 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses McCrae(a) RESIDENCE. No. 915 Sharp St  
(Usual place of abode)ST. 23 WARD. 23  
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18937 AGE Years Months Days If LESS than 1 day, hrs. or min.  
28 -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina10 NAME OF FATHER Thomas McCrae11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina14 Informant Hospital Records,  
(Address) Municipal Hospital15 Filed Robert P. Harrison,  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7 192217 I HEREBY CERTIFY, That I attended deceased from February 7, 1922, to February 7, 1922  
that I last saw him alive on February 7, 1922  
and that death occurred, on the date stated above, at 3:15 P.M.  
The CAUSE OF DEATH\* was as follows:Urthral stricture  
1 yr.CONTRIBUTORY Pylonephritis; Uremia  
(Secondary) (duration) yrs. mos. ds. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? K.P.N. etc(Signed) Clyde M. Hall M. D.2/10/22 Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

ADDRESS

FEB 1 1922

Information should be carefully supplied. All should be stated in plain terms, so that it may be properly classified. Exact statement of OCCASION CAUSE OF DEATH is very important. See instructions on back of certificates.

B 11 1922

Burial Permit Clerk

Registrar

JOHNS HOPKINS HOSPITAL

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Probably Gonococcus  
Infection.*

D 61183 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61183

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 347 W. Preston Street ST. 11 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Buettner

(a) RESIDENCE. No. 347 W. Preston  
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 10 mos. 3 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Elizabeth Donnelly

6 DATE OF BIRTH (month, day, and year) April 5, 1871

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
50 10 3

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing Cutter

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland

10 NAME OF FATHER Conrad Buettner

11 BIRTHPLACE OF FATHER (city or town) Germany  
(State or country)

12 MAIDEN NAME OF MOTHER Alelia

13 BIRTHPLACE OF MOTHER (city or town) Germany  
(State or country)14 Informant Mrs. Elizabeth Buettner  
(Address) 347 W. Preston Street

15 J. E. Wehn Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Dec. 29, 1921, to Feb. 9, 1922.

That I last saw him alive on Feb. 8, 1922.

and that death occurred, on the date stated above, at 4 A. M.

The CAUSE OF DEATH\* was as follows:

Chronic interstitial nephritis

(duration) 2 yrs. -- mos. -- ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. N. Pelletier M. D.

19 (Address) 817 Hamilton Terrace

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Cemetery

213, 1922

20 UNDERTAKER

ADDRESS

Henry W. Mears &amp; Son 805 N. Calvert





D 61185 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61185

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital, Ward)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel V. Moore.

(Residence in Baltimore: No. 1207 Battery Ave. St.; yrs. 4 mos. 5 24 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female. 4-COLOR OR RACE, White. 5-Single, Married, Widowed or Divorced, Single. (Write the word.)

6-DATE OF BIRTH, August 16th, 1917. (Month) (Day) (Year)

7-AGE, 4 yrs. 5 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None. (b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, James C. Moore.

11-BIRTHPLACE OF FATHER, (State or Country), Harford Co. Md.

12-MAIDEN NAME OF MOTHER, Annabel Parks.

13-BIRTHPLACE OF MOTHER, (State or Country), A. A. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annabel Moore. (mother)

(Address) 1207 Battery Ave.

15- Robert P. Harrison, Registrar.

Filed 1922

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 9th, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry and that said deceased came to death on the day stated above. (Inquest, autopsy or Inquiry.)

The CAUSE OF DEATH\* was as follows:

Burns about face and body.

Playing with stove-fire.

Accidental death.

(Duration) yrs. mos. ds.

## CONTRIBUTORS

(Secondary) (Duration) yrs. mos. ds. (Signed) E. J. Harrison, M. D. (Coroner)

Feb. 9th, 1922 (Address) 1019 1/2 Charles St.

\*State the Disease causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death? 1207 Battery Ave, Feb. 9, 1922 10 a.m.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Cedar Hill Cemetery Feb. 11, 1922

20-UNDERTAKER, ADDRESS, E. J. Harrison &amp; Son - 1460 Battery Ave.

D 61186

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61186

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (Municipal Tuberculosis Hospital) 19 WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Russell Johnson

(a) RESIDENCE. No. 205 N. Parrish st.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown

mos.

How long in U. S., if of foreign birth? 10 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

Colored

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER Augustus James

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER Carrie Johnson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant Hospital Records (Address) M.T.H.

15

Robert P. Harrison, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8, 1922

17

I HEREBY CERTIFY, That I attended deceased from November 14, 1921, to Feb. 8, 1922.

that I last saw him alive on Feb. 8, 1922.

and that death occurred, on the date stated above, at 4.20 p.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY Peritonitis (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed)

2-8-22

(Address) Municipal Tbc. Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

ADDRESS

A. Jones

207 S. Stucker

Information should be carefully supplied. All statements of cause of death should be in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B 11 1922

D 61187

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61187

## CERTIFICATE OF DEATH.

101-001

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

St. Joseph's Hospital ST.

WARD) 10

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Hom Wong

(a) RESIDENCE. NO.

700 N. High

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Yellow Chinese

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Married

6 DATE OF BIRTH (month, day, and year)

unknown

7 AGE

Years

Months

Days

57

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundryman 041

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

China

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

unknown

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

unknown

14

Informant (Address)

Hom Doo 700 N. High St.

15 Filed

Permit P. H. H. H. H. H.

Registrar

John O. Mitchell 1204 N. Fayette

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8, 1922

17 I HEREBY CERTIFY, That I attended deceased from

Feb. 7, 1922, to Feb. 8, 1922.

that I last saw him alive on Feb. 8, 1922.

and that death occurred, on the date stated above, at 4.30 P. M.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Herman J. Boy, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Cemetery Feb. 13, 1922

20 UNDERTAKER

ADDRESS

Information should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

BY 11 1922

D 61188

HEALTH DEPARTMENT—CITY OF BALTIMORE D 61188

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victoria Davis(a) RESIDENCE. No. 607 Central ave.

ST.

WARD.

(Usual place of abode)

30 years

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofUnknown6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day. hrs. or min.
	44			

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Maryland10 NAME OF FATHER Clem Lewis11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Unknown14 Informant Hospital Records  
(Address) M.T.H.15 Filed Robert P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10, 192217 I HEREBY CERTIFY, That I attended deceased from  
April 20, 1921, to Feb. 10, 1922.that I last saw her alive on Feb. 9, 1922.and that death occurred, on the date stated above, at 2:20 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(duration) 2 yrs. 9 mos. da.CONTRIBUTORY Tuberculous enteritis  
(Secondary) (duration) 6 mos. da.18 Where was disease contracted  
If not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed)

Francis L. Padaghi M.D.  
-10-22 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Urbury

DATE OF BURIAL

Feb 17 1922

20 UNDERTAKER

John W. HendersonADDRESS 1502Emmourt

Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCASION should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

B 11 1922

Burial Permit Clerk.



D 61189

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61189

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2400 Fairfield ST.; 25 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2400 Fairfield

St.; 24 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Cul

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

6-DATE OF BIRTH,

(Month) (Day) (Year) 1879

7-AGE

43

If LESS than 1 day,  
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular  
kind of work...  
(b) General nature of industry, busi-  
ness, or establishment in which  
employed (or employer)...

Laborer

9-BIRTHPLACE,

(State or Country),

N.C.

10-NAME OF  
FATHER,

Unknown

11-BIRTHPLACE  
OF FATHER

(State or Country),

N.C.

12-MAIDEN NAME  
OF MOTHER

Unknown

13-BIRTHPLACE  
OF MOTHER

(State or Country),

N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

15-

Robert P. Harrison

Filed

11 1922

Burial Permit Clerk. Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year) Feb - 9, 1922

17- I HEREBY CERTIFY, That I attended deceased from

Oct-15 1921, to Feb-9- 1922,

that I saw him alive on Feb 8- 1922,

and that death occurred, on the date stated above, at 3:15 a.m.

The CAUSE OF DEATH was as follows:

Acute valvular heart  
disease

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY  
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed)

Feb 10, 1922 (Address) 2034 No. 1st St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Furnish Branch Feb 16 1922

20-UNDERTAKER

ADDRESS

Hessons 1405 Meekdeny

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61190

## CERTIFICATE OF DEATH.

31 D 61190

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 949 Homestead St. ST.;

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Regina Sparks(a) RESIDENCE. NO. 949 Homestead St. ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 13/1905

## 7 AGE

Years

Months

Day

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant (Address)

## 15

Filed

Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 10/1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 3rd, 1922, to Feb 10/22, 1922 that I last saw her alive on Feb 10/22, 1922 and that death occurred, on the date stated above, at 8:30 a m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical Exam(Signed) W. W. Harrison M.D.Address 401 E 25th St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Mary's Goreville Feb. 15 1922

20 UNDERTAKER

ADDRESS

Richard F. Cunley 488 C. Ave

B 11 1922

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

61191  
D 61191

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 McCulloh

ST. 11 WARD

## 2-FULL NAME

Hamilton Johnson

(a) RESIDENCE. NO. 918 McCulloh

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male Colored Married

5a If married, widowed, or divorced

HUSBAND of Sarah Julia Johnson

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 10 1856

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

76

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

Has not worked for 12 yrs

(c) Name of employer

9 BIRTHPLACE (city or town)

Montgomery Co Md

(State or country)

10 NAME OF FATHER

Jason Johnson

11 BIRTHPLACE OF FATHER (city or town)

Montgomery Co, Md

(State or country)

12 MAIDEN NAME OF MOTHER

Janet Johnson

13 BIRTHPLACE OF MOTHER (city or town)

Montgomery Co Md

(State or country)

14

Informant

(Address)

Julia Johnson, 918 McCulloh St.

15

File

FEB 12 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 8 1922, to Feb 9 1922.

that I last saw him alive on Feb 8 1922.

and that death occurred, on the date stated above, at 10:10 P. m.

The CAUSE OF DEATH\* was as follows:

Locomotor Ataxia (duration) 12 yrs. mos. ds.

CONTRIBUTORY Age - Arterio Sclerosis (Secondary) (duration) 4 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) William N. May Jr. M. D.

Feb 10, 1922 (Address) 1209 Presden

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laurel, Maryland, Feb 12 1922

20 UNDERTAKER

ADDRESS 1303

James H. Dennis

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Probably luetic in origin*



N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61192

## CERTIFICATE OF DEATH.

163 D 61192

### 1-PLACE OF DEATH

CITY OF BALTIMORE (No.

934 St. Chester St

ST.

WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### 2-FULL NAME

Baby Fisher

(Residence in Baltimore: No.

934 St. Chester St

St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

#### 3-SEX.

Male

#### 4-COLOR OR RACE,

White

#### 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.

Single

#### 6-DATE OF BIRTH,

Jan 17

1922

#### 7-AGE,

25

If LESS than 1 day,

hrs. or min.?

#### 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

000

#### 9-BIRTHPLACE.

(State or Country),

Baltimore Md

#### 10-NAME OF FATHER,

Abraham Fisher

#### 11-BIRTHPLACE OF FATHER

(State or Country),

Russia

#### 12-MAIDEN NAME OF MOTHER

Goldie Golden

#### 13-BIRTHPLACE OF MOTHER

(State or Country),

Russia

#### 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jack Lewis

(Address)

1439 E. Baltimore St

15-FEB 12 1922

ROBERT R. KRAUTER,

Filed..... 191.....

Burial Permit: Clerk

### CORONER'S CERTIFICATE OF DEATH.

#### 16-DATE OF DEATH,

Jul. 11, 1922

(Month)

(Day)

(Year)

#### 17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lock of cord

(Duration) yrs. mos. ds.

#### CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. M. D.

(Coroner.)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

#### 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

#### Former or usual residence.....

#### 19-PLACE OF BURIAL OR REMOVAL

#### DATE OF BURIAL,

Workmen Circle Feb 12, 1922

#### 20-UNDERTAKER

#### ADDRESS

Jack Lewis 1411 E. Baltimore St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61193

## CERTIFICATE OF DEATH.

15<sup>b</sup> D 61193

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST. 15 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Bernard Baum(a) RESIDENCE NO. 2600 Ullman Ave. ST. Left WARD Left

(Usual place of abode)

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Left yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of Left6 DATE OF BIRTH (month, day, and year) Nov 10 18877 AGE Years 35 Months — Days — If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore10 NAME OF FATHER Milton Baum11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Delia Baum13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant (Address) Jack Lewis 1439 E. Pratt St.15 FEB 12 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/10/22 1917 I HEREBY CERTIFY, That I attended deceased from 2/5/22, 19 to 2/10/22, 19 that I last saw him alive on 2/10/22, 19 and that death occurred, on the date stated above, at 12:30 P. M. The CAUSE OF DEATH\* was as follows:Streptococic MeningitisCONTRIBUTORY (Secondary) Acute Mastoiditis (duration) yrs. mos. 5 ds.(duration) yrs. mos. 6 ds.18 Where was disease contracted if not at place of death? NoDid an operation precede death? Yes Date of 2/5/22Was there an autopsy? No

What test confirmed diagnosis?

(Signed) 24 Zimberg, M. D.2/10, 1922 (Address) Hebrew Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew20 UNDERTAKER Jack LewisDATE OF BURIAL 2-12-22ADDRESS 1439 E. Pratt St.

Every item should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61194

## CERTIFICATE OF DEATH.

74-001 1854  
D 61194  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *4305 Pennington Ave* ST. *WARD*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *4305 Pennington Ave* St.; *68* yrs., *—* mos., *—* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

SEX *Female* COLOR OR RACE *White* 5-SINGLE, *Married* *Widowed* *Divorced*  
(Write the word.)

## 6-DATE OF BIRTH

*Feb* *11* *1884*  
(Month) (Day) (Year)*68* yrs. *—* mos. *—* ds. If LESS than 1 day, *—* hrs. or *—* min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work *None*  
(b) General nature of industry, business, or establishment in which employed (or employer) *None*9-BIRTHPLACE,  
(State or Country).

## 10-NAME OF FATHER

11-BIRTHPLACE OF FATHER  
(State or Country).

## 12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country).

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15-

Filed

191

ROBERT R. KRAUTER,

Burial Permit Clerk

FEB 12 1922

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*February 11* *1922*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Dec* *1906*, to *Feb 11* *1922*,that I saw him alive on *Feb 4* *1922*,and that death occurred, on the date stated above, at *5:30* m.

The CAUSE OF DEATH\* was as follows:

*Hemiplegia*  
(Duration) *1* yrs. *1* mo. *—* ds.CONTRIBUTORY  
(Secondary)(Duration) *1* yrs. *—* mo. *—* ds.(Signed) *Robert R. Krauter* M. D.*Feb 11*, *1922* (Address) *4305 Pennington Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs. *—* mos. *—* ds. In the State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Greenmount* *Feb 13*, *1922*20-UNDERSTANDING ADDRESS *2139 Royal**all*

N.B.—Every item of information furnished is very important. See instructions on back of certificate.



# Apoplectic hemiplegia

**STATEMENT OF OCCUPATION.**—Pre statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

*peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc. (name origin; "Cancer" is definite, avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

*Abortion, Cellulitis, Childbirth, Convulsions, Hamorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.*

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (if induced), whether death is directly or indirectly due to the same.



Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-11-1915 Co.—1000 Bks.  
D 61195

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

46 D 61195

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Greenway Apartment A ST. 11 WARD)

### 2-FULL NAME

Bessie Buckler

(a) RESIDENCE. NO. Greenway Apartment A WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 11 1859

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 62 9 —

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Leslie Heppner Buckler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Clara Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14

Informant Warren Buckler (Address) 806 Calhoun St

15

FEB 12 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 19 22

17 I HEREBY CERTIFY, that I attended deceased from April 21 Feb 11 19 22 that I last saw her alive on Feb 11 19 22 and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of ovary (duration) 1 yrs. — mos. — ds.

CONTRIBUTORY General metastases (Secondary) (duration) 6 yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of April 1922

Was there an autopsy?

What test confirmed diagnosis? Prognosis of tumor

(Signed) Warren Buckler M. D.

, 19 (Address) 806 Calhoun St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cem Feb 13 19 22

20 UNDERTAKER

ADDRESS

Harry Jenkins & Co Orchard St. Charles

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61196

## CERTIFICATE OF DEATH.

D 61196

## 1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *2402 N Charles St* ST. *17* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Joseph E. Trippe*(a) RESIDENCE. NO. *2402 N Charles St* ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Male**White**Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*May 28<sup>th</sup> 1845*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*76**9**14*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md*

10 NAME OF FATHER

*Joseph E Trippe*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Maryland*

12 MAIDEN NAME OF MOTHER

*Sarah E Brown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Baltimore Md*

14

Informant (Address)

*Miss P. E. Trippe  
2402 N Charles St*

15

Filed

FEB 12 1922

Burial Permit City

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 11* 1922

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 15*, 1922, to *Feb. 11*, 1922,  
that I last saw him alive on *Feb. 10*, 1922,and that death occurred, on the date stated above, at *6<sup>10</sup> A. M.*

The CAUSE OF DEATH\* was as follows:

*Broncho-pneumonia*(duration) yrs. mos. *24* ds.CONTRIBUTORY *Myocardial insufficiency*  
(Secondary)(duration) yrs. mos. *3* ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No.*What test confirmed diagnosis? *Chinise symptoms*(Signed) *Arthur F. Robinson*, M. D.2/11 1922 Address) *1307 N Charles St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Greenmount Cem* *Feb 13*

20 UNDERTAKER

ADDRESS

*Henry Jenkins & Co* *Orchard*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61197

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *2818 Kennedy St.* WARD *9*)

## 2. FULL NAME

*John A. Becker*(a) RESIDENCE NO. *2818 Kennedy St.* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *62* yrs. *9* mos. *4* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male White Married*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Carolina Becker*6 DATE OF BIRTH (month, day, and year) *May 6 1859*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*62 9 4*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Real Estate*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore*

10 NAME OF FATHER

*Severine Becker*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Germany*

12 MAIDEN NAME OF MOTHER

*Treacher*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Germany*

14

Informant

*Caroline Becker*

(Address)

*2818 Kennedy St.*

15

Filed

*FEB 12 1922*  
*Burial Permit Clerk*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 10 - 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 9 - 1922* to *Feb 10 1922*that I last saw him alive on *Feb 10 1922*and that death occurred, on the date stated above, at *10 p.m.*

The CAUSE OF DEATH\* was as follows:

*Valvular dis of heart -*CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

*Pulmonary Tuberculosis*

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *exam*(Signed) *Thos. J. Brown*, M. D., 19 (Address) *1255 Bldg*

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Baltimore County Feb 13 1922*  
*Louis's Heemann 326 Broad*  
*way*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61198

## CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 27)

FULL NAME

(Residence in Baltimore: No. 23 Rosebury Ave)

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. da.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

Feb 9, 1916

7-AGE,

6 yrs., 4 mos., 4 da.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

School Boy

9-BIRTHPLACE, (State or Country).

Baltimore

10-NAME OF FATHER

William C. Kehs

11-BIRTHPLACE OF FATHER (State or Country)

Phila Pa

12-MAIDEN NAME OF MOTHER

Bessie E. Shimp

13-BIRTHPLACE OF MOTHER (State or Country).

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

William C. Kehs

(Address)

23 Rosebury Ave

15-

FEB 12 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Feb. 11, 1922

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Haemorrhage  
due to automobile  
(Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)

(Signed) M. J. Smith, M. D.  
2-11-22 (Address) M. J. Smith

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore

DATE OF BURIAL,

Feb. 12, 1922

20-UNDERTAKER

William C. Kehs

ADDRESS

502 E North





D 61200

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

H9 D 61200

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Southern Hospital 16* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *John C. Haesloop*(a) RESIDENCE. NO. *619 N Calhoun* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *47* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Male White Married*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

*Samuel S. Haesloop*

6 DATE OF BIRTH (month, day, and year)

*June 15 1873*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*47 7 26*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Plumber 059*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md*

10 NAME OF FATHER

*Henry Haesloop*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Wilhelmina*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Baltimore Md*

14

Informant (Address)

*Samuel S. Haesloop 619 N Calhoun St*

15

FEB 12 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 11 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*July 1921*, to *Feb 9 1922*,that I last saw him alive on *Feb 8th 1922*and that death occurred, on the date stated above, at *7:30 a m.*

The CAUSE OF DEATH\* was as follows:

*Suppurative Carcinoma Throat*  
(duration) yrs. *9* mos. ds.

CONTRIBUTORY (Secondary)

*Asthma*  
(duration) yrs. *8* mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *By Dr. W. C. Gray* M. D.(Address) *400 N. Payson*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Western**Feb 13 1922*

20 UNDERTAKER

ADDRESS

*Geo W Little 2700 Edmondson Ave*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

K  
A  
D  
O  
K

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

D 61201

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61201

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 Abbott ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence J. Heldebrandt

(a) RESIDENCE. No. 1618 Abbott ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) 9/11/1921

7 AGE Years 3 Months 10 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

10 NAME OF FATHER Vincent Heldebrandt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Rose Agak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Vincent Heldebrandt (Address) 1618 Abbott St

15 Filed FEB 12 1922 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1922

I HEREBY CERTIFY, That I attended deceased from 7 1922, to Feb 10 1922, that I last saw him alive on Feb 10 1922.

and that death occurred, on the date stated above, at 7:45 P. M.

The CAUSE OF DEATH\* was as follows:

Congenital Heart Disease

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. R. Smith M. D. Feb 12 1922 801 N. Avenue

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Redeemer Feb 13 1922

20 UNDERTAKER ADDRESS

Smith & Son 1806 Lombard St

D 61202

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

61202

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 N. Durham ST.: 7 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katharine Brusak(a) RESIDENCE. No. 918 N. Durham ST. 7 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds.How long in U. S., if of foreign birth? 42 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wenceslaus Brusak6 DATE OF BIRTH (month, day, and year) Feb 10 1922

7 AGE

Years 61

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia10 NAME OF FATHER Joe. M. Lieke11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia12 MAIDEN NAME OF MOTHER W. H. Knorr13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14

Informant Mary E. Brusak  
(Address) 918 N. Durham St.

15

Filed

FEB 12 1922

ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 1, 1921 to Feb 10, 1922 that I last saw him alive on Feb 9, 1922 and that death occurred, on the date stated above, at 9:30 A. M.

The CAUSE OF DEATH\* was as follows:

Coronary atherosclerosis(duration) yrs. 4 mos. ds.CONTRIBUTORY (Secondary) Arteriosclerosis(duration) yrs. 1 mos. ds.18 Where was disease contracted if not at place of death? unknownDid an operation precede death? NoDate of Nov 21Was there an autopsy? NoWhat test confirmed diagnosis? findings(Signed) J. J. Phyzical

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy RedeemerDATE OF BURIAL Feb 13 192220 UNDERTAKER Frank BrocktonADDRESS 1906 Ashland

Physician should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61203

## CERTIFICATE OF DEATH

11-001 D 61203

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. *Kernan Hospital*)

ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Walter Mitchell Ford*

(Residence in Baltimore: No. *1017 W 37th St*)

St. 6 yrs. 6 mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *W* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Single* (Write the word)

6-DATE OF BIRTH *August 10, 1915* (Month) (Day) (Year)

7-AGE *6* yrs. *6* mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work *School boy* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Baltimore, Md*

10-NAME OF FATHER *John Mitchell Ford*

11-BIRTHPLACE OF FATHER (State or country) *Baltimore, Md.*

12-MAIDEN NAME OF MOTHER *Clara May Miller*

13-BIRTHPLACE OF MOTHER (State or country) *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *William H. Hume*

(Address) *1702 N. Charles St.*

15-*FEB 12 1922* ROBERT R. KRAUTER, REGISTRAR

Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *February 10, 1922* (Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from *Jan 25, 1922* to *Feb 10, 1922* that I saw him alive on *February 10, 1922* and that death occurred, on the date stated above, at *3:10 P. m.* The CAUSE OF DEATH\* was as follows:

*Pneumonia*

(Duration) yrs. mos. ds.

Contributory (SECONDARY) *Influenza*

(Duration) yrs. mos. ds.

(Signed) *William H. Hume* M. D. *Feb. 10, 1922* (Address) *110 N. Charles St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *St Mary's Hospital* DATE OF BURIAL *Feb 13, 1922*

20-UNDERTAKER *W. S. Marshall* ADDRESS *3539 Fall Road*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Baran  
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61204

CERTIFICATE OF DEATH.

100-001 D 61204  
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 320 S Ann ST. WARD)

2-FULL NAME

(Residence in Baltimore: No. 320 S Ann st

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

FEB 12 1922

ROBERT R. KRAUTER,

Registrar,  
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

investigation and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Pneumonia  
(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry J. Smith, M. D.

(Coroner.)

1922 (Address) 1803 Bank

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

John M. Weber

1803 Bank

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

61205

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *4th. Sec. 1100* ST. *13* WARD)

2-FULL NAME *Lois Bernice Daumenberg*

(Residence in Baltimore: No. *903 Leucate St.*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word) *single*

6-DATE OF BIRTH, *Aug. 19, 1912*  
(Month) (Day) (Year)

7-AGE, *9 yrs. 5 mos. 22 ds.* IF LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *Student*  
(b) General nature of industry, business, or establishment in which employed (or employer) *MOO*

9-BIRTHPLACE, (State or Country), *M. C.*

10-NAME OF FATHER, *Joseph E. Daumenberg*

11-BIRTHPLACE OF FATHER (State or Country), *M. C.*

12-MAIDEN NAME OF MOTHER *Evelyn Norvick*

13-BIRTHPLACE OF MOTHER (State or Country), *Texas*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Alb. Daumenberg*

(Address) *2256 Linden Ave.*

15- *ROBERT R. KRAUTER,*

*Burial Permit Clerk.*

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb. 11, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.)

*quest* find that said deceased came to *death* (topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Fracture of skull*

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) *automobile accident*

(Duration) ... yrs. ... mos. ... ds.

(Signed) *J. T. Heermans* M. D. (Coroner.)

*Feb. 11, 1922* (Address) *2807 Edmondson Ave.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place *4th. Sec. 1100* In the of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? *on Linden Ave. near Leucate St.*

Former or usual residence *903 Leucate St.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *Balto. Hebrew Cem. 2/13/1922*

20-UNDERTAKER ADDRESS *David Sandheim 118 W. Mt. Royal Ave.*

D 61206

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61206

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1264 Riverside Ave* ST. *74* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Walter A. Becker*(a) RESIDENCE. No. *1264 Riverside Ave.* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence: in city or town where death occurred *47* yrs. *11* mos. *8* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Lottie Becker*6 DATE OF BIRTH (month, day, and year) *March 3<sup>rd</sup> 1874*7 AGE Years *47* Months *11* Days *8* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Painter*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *Conrad Becker*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Wickwood*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*14 Informant *Lottie Becker* (Address) *1264 Riverside Ave.*15 Filled *FEB 12 1922* 19 *ROBERT R. KRAUTER*

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 11<sup>th</sup> 1922*17 I HEREBY CERTIFY, That I attended deceased from *Feb 6* 19 *22*, to *Feb 11* 19 *22*.that I last saw him alive on *Feb 10* 19 *22*, and that death occurred, on the date stated above, at *4:15* *PM*.

The CAUSE OF DEATH\* was as follows:

*Pulmonary tuberculosis*

CONTRIBUTORY (Secondary)

*Unknown* (duration) yrs. mos. ds. *Tuberculosis longitudo* (duration) yrs. mos. ds. *Probably 3 mos*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Phys*(Signed) *Wm. B. B. B.* M. D. *7/2 19 22* (Address) *1319 Light St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Cedar Hill Cemetery* *Feb. 14<sup>th</sup> 1922*

20 UNDERTAKER ADDRESS

*Wm. H. John H. Trefel & Son* *801 W. Fayette*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 61207

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74001 61207

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2127 E. Baltimore ST.; WARD)

2-FULL NAME Elizabeth Johnston Elliott

(a) RESIDENCE. No. 2127 E. Baltimore St. ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX + 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced (write the word) m.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos. J. R. Elliott.

6 DATE OF BIRTH (month, day, and year) Sept 8-1846

7 AGE Years 75 Months 5 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work at Home 037 (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) Batt Ind. (State or country)

PARENTS

10 NAME OF FATHER Wm A. Johnston

11 BIRTHPLACE OF FATHER (city or town) Balt (State or country)

12 MAIDEN NAME OF MOTHER Mary Turner

13 BIRTHPLACE OF MOTHER (city or town) Balt (State or country)

14 Informant Thos. J. R. Elliott (Address) 2127 E. Baltimore St.

15 FEB 12 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/11/22

17 I HEREBY CERTIFY, That I attended deceased from 12/10/21, 19 to 2/10/22, 19 that I last saw him alive on 2/10/22, 19 and that death occurred, on the date stated above, at 12:10 a. m. The CAUSE OF DEATH\* was as follows:  
Arteriosclerosis  
(duration) 10 yrs. mos. ds.  
CONTRIBUTORY Hemiplegia (Secondary) (duration) yrs. mos. 10 ds.  
18 Where was disease contracted if not at place of death?  
Did an operation precede death? Date of  
Was there an autopsy? no  
What test confirmed diagnosis?  
(Signed) H. E. Hughes, M. D.  
(Address) 414 N. Bway  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)  
19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL  
Greenmount Cemetery Feb 13 1922  
20 UNDERTAKER ADDRESS  
H. E. Hughes 414 N. Bway.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61208

D 61208

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs

mos

ds

How long in U. S., if of foreign birth?

yrs

mos

ds

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town, State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town, State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town, State or country)

14

Informant (Address)

15

FEB 12 1922

ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

HEREBY CERTIFY, That I attended deceased from

Feb. 8, 1922, to Feb. 10, 1922, that I last saw him alive on Feb. 10, 1922, at 8:12 P. M.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D. (Address) 2701 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61209

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 Woodlawn Road

ST. 27<sup>th</sup> WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Sarah Amanda Hughes

(a) RESIDENCE. No. 307 Woodlawn Road

ST. 27<sup>th</sup> WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs 8 mos 3 ds. How long in U. S., if of foreign birth? — yrs — mos — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Thomas B. Hughes

6 DATE OF BIRTH (month, day, and year)

June 8 - 1844

7 AGE

Years

Months

Days

If LESS than 1 day, — hrs. or — min.

77

8

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Harford Co. Maryland

10 NAME OF FATHER

Samuel B. Silver

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Harford Co. Md.

12 MAIDEN NAME OF MOTHER

Sarah Astor

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Harford Co. Maryland

14

Informant

(Address)

Mrs Mary C. Silver

307 Woodlawn Road

15

Filed

FEB 12 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 11 1922

17

I HEREBY CERTIFY, that I attended deceased from

Jan 1, 1914, to Feb 11, 1922.

that I last saw her alive on Feb 8, 1922.

and that death occurred, on the date stated above, at 12-10 A. M.

The CAUSE OF DEATH\* was as follows:

General Arteriosclerosis  
Cerebral Hemorrhage

CONTRIBUTORY

(Secondary)

of Diphtheria &amp; Erysipelas

(duration)

8 yrs. 1 mos. — ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. S. Silver

2/11, 1922

Address) 422 Roland Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Star Creek Cemetery Harford Co. Md.

Feb 13 1922

20 UNDERTAKER

ADDRESS

H. Hughes 422 St. Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61210

## CERTIFICATE OF DEATH.

113 D 61210

### PLACE OF DEATH

CITY OF BALTIMORE (No. 4 N. Front RT

ST. 5

WARD)

### FULL NAME

Baby Jacobs

(Residence in Baltimore: No. 4 N. Front RT

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

#### 3-SEX

Male

#### 4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

#### 6-DATE OF BIRTH

Aug. 26th

1921

(Month)

(Day)

(Year)

#### 7-AGE

5 yrs. 17 mos. 17 ds.

#### 10 LESS than 1 day

hrs. or min.

#### 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

#### 9-BIRTHPLACE

(State or Country), Balt. Md.

#### 10-NAME OF FATHER

Harry Jacobs

#### 11-BIRTHPLACE OF FATHER

(State or Country), Balt. Md.

#### 12-MAIDEN NAME OF MOTHER

Dora Bogatzky

#### 13-BIRTHPLACE OF MOTHER

(State or Country), Balt. Md.

#### 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Hannah Lewis

(Address), 1439 E. Balt.

#### 15-

FILED

FEB 12 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

### CORONER'S CERTIFICATE OF DEATH.

#### 16-DATE OF DEATH

Feb. 12th

1922

(Month)

(Day)

(Year)

#### 17-

I HEREBY CERTIFY, that I took charge of the

remains described above, held in

request, autopsy or inquiry.)

thereon and from the evidence obtained by said

(request, au-

that said deceased came to death today or inquiry on the day stated above.

THE CAUSE OF DEATH was as follows:

Ac Bact

#### CONTRIBUTORY (Secondary)

(Signed) J. H. Slader

(Duration) yrs. mos. ds.

(Coroner)

(Address) 1439 E. Balt.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

#### 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

#### 19-PLACE OF BURIAL, OR REMOVAL,

Hebrew Frindschif

#### DATE OF BURIAL,

Feb. 12, 1922

#### 20-UNDERTAKER

Jack Lewis

#### ADDRESS

1407 E. Balt.



## *Gastro intestinal disturbance*

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*,

*peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia," (merely symptomatic), "At-rophy," "Collapse," "Coma," "Convulsions," "De-bility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite dis-ease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicæmia," "PUERP-ERAL peritonitis," etc. State cause for which sur-gical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Ex-amples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homi-cide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional in-formation which may give any of the following diseases, without explanation as the sole cause of death:

<i>Abortion,</i>	<i>Hæmorrhage,</i>	<i>Meningitis,</i>	<i>Phlebitis,</i>
<i>Cellulitis,</i>	<i>Gangrene,</i>	<i>Miscarriage,</i>	<i>Pyæmia,</i>
<i>Childbirth,</i>	<i>Gastritis,</i>	<i>Necrosis,</i>	<i>Septicæmia,</i>
<i>Convulsions,</i>	<i>Erysipelas,</i>	<i>Peritonitis,</i>	<i>Tetanus.</i>

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved): *Suicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61211

## CERTIFICATE OF DEATH.

D 61211

1-PLACE OF DEATH

Malbrook

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

1713 Rosedale Ave.

ST.

WARD)

2-FULL NAME

Hasuda Selenesky

(a) RESIDENCE NO.

1209 St Matthew

ST.

WARD

(Usual place of abode)

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred

28

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

28

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

David Selenesky

6 DATE OF BIRTH (month, day, and year)

1872

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

50

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Housewife

9 BIRTHPLACE (city or town)

(State or country)

Russia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant (Address)

Jack Lewis 1411 E. Balto

15

FEB 12 1922

ROBERT N. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/12 1922

17

I HEREBY CERTIFY, That I attended deceased from

February 19 22, to February 12, 1922.

that I last saw him alive on February 11, 1922.

and that death occurred, on the date stated above, at 6 am.

The CAUSE OF DEATH\* was as follows:

Pneumo-pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

Myocardial infarct

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death? 1209 St Matthew St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Physical Exam

(Signed)

August 9, 1922, M. D. 1831 Park Ave

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Reverend Rosehill

2/12 1922

Jack Lewis 1411 E. Balto

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 61212

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 61212

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *802 W 34th* ST.; *13* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

*Francis Hammond*

(a) RESIDENCE. No. *802 W 34th* ST.,

(Usual place of abode)

WARD.

Length of residence in city or town where death occurred *50* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If nonresident give city or town and State)

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*F*

4 COLOR OR RACE

*W*

5 Single, Married, Widowed,

or Divorced (write the word)

*Widowed*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

*N*

*Hammond*

6 DATE OF BIRTH (month, day, and year)

*Jan 16 1845*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

*77*

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

*None*

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

*MD*

10 NAME OF FATHER

*Unknown*

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

*Unknown*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

*Unknown*

14

Informant  
(Address)

*Annie Anthony*  
*802 W 34th*

15

Filed

*FEB 12 1922*

*ROBERT A. KRAUTER*

Registrar

*Serial Permit Clerk*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb 11 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 3, 1922, to Feb 6, 1922,*

that I last saw her alive on *Feb. 6, 1922,*

and that death occurred, on the date stated above, at *6 A.M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Myocarditis  
& arteriosclerosis*

*Unknown* (duration) yrs. mos. ds.

CONTRIBUTORY *Cardiac dilatation*  
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Wm. M. D.*

*Fell 1922* (Address) *3429 Chestnut St*

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Landon Park*

*Feb 13 22*

20 UNDERTAKER

*Chenoweth & Son*

61213

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61213

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *705 Bay*)ST. *13* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*William H. Crue*(a) RESIDENCE. No. *705 Bay*

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *18* yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*2M*

4 COLOR OR RACE

*W*

5 Single, Married, Widowed, or Divorced (write the word)

*Married*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

*Elizabeth Crue*

6 DATE OF BIRTH (month, day, and year)

*Aug 1 1859*

7 AGE

*62*

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*M.D.*

10 NAME OF FATHER

*John Crue*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*M.D.*

12 MAIDEN NAME OF MOTHER

*Elizabeth Proby*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*M.D.*

14

Informant (Address)

*Elizabeth Crue 705 Bay*

15

FEB 12 1922

ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 10 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 4* 1922, to *Feb 10* 1922that I last saw him alive on *Feb 10* 1922and that death occurred, on the date stated above, at *3 P.*

The CAUSE OF DEATH\* was as follows:

*Broncho pneumonia*(duration) yrs. mos. *6* ds.

CONTRIBUTORY (Secondary)

*Pulmonary edema*(duration) yrs. mos. *1* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? *Examp.*(Signed) *W. M. D.*(Address) *3429 Chestnut St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*St Marys Hampden Feb 13 1922*

20 UNDERTAKER ADDRESS

*Chenoweth Son Chestnut*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.



Physicians should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

9 61214

90 61214

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3002 E. Fayette ST., 6 WARD)

### 2-FULL NAME

Louise Sautter

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 3002 E. Fayette ST., 6 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 3 mos. 3 ds. How long in U. S., if of foreign birth? 37 yrs. 3 mos. 3 ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andreas Sautter

6 DATE OF BIRTH (month, day, and year) Aug 26-1849

7 AGE Years 72 Months 5 Days 14 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

at home

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER Fritz Huber

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14 Informant Edward Sautter

(Address) 3002 E. Fayette St

15 FEB 12 1922 ROBERT R. KRAUTER

Filed

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1921, to Feb 10, 1922, that I last saw him alive on Feb 10, 1922, and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? exam.

(Signed) B. Kelly M. D.

Baltimore, 1922 (Address) 10020 Elmwood Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Woodlawn Cem.

20 UNDERTAKER

F. C. Trause & Son

DATE OF BURIAL

Feb. 13 1922

ADDRESS

1032

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No hemorrhage. Not  
apoplectic. Chronic  
myocarditis.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61215

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3729 Fernwood Ave ST.: 76 WARD)

## 2-FULL NAME

Irvin Allen

## (a) RESIDENCE. NO.

3729 Fernwood Ave

WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred

6 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of-

## 6 DATE OF BIRTH (month, day, and year)

July 2-1897

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.2479

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Spotsylvania Co. Va.

## 10 NAME OF FATHER

Wm. Allen11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Va.

## 12 MAIDEN NAME OF MOTHER

Cora V. Melsee13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Va.

## 14

Informant  
(Address)John B. White  
3927 Fernwood Ave

## 15

Filed

FEB 12 1922ROBERT R. KRAUTER  
Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 19 2217 I HEREBY CERTIFY, That I attended deceased from  
1/28/22 19 to 2/11/22 19  
that I last saw him alive on 2/11/22 19  
and that death occurred, on the date stated above, at 7:30 p. m.

The CAUSE OF DEATH\* was as follows:

Osteo-sarcoma  
metastaticCONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL  
Frederick Co., Va.  
Spotsylvania Co., Va.

DATE OF BURIAL

Feb 14 19 22

ADDRESS

1739 E. Esage

## 20 UNDERTAKER

Girkler + Girkler  
L. W. G.

Physicians should state EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61216

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 Strathmore Ave ST. 27 WARD)

2-FULL NAME Ann Maria Hinton

(a) RESIDENCE. No. 14 Strathmore Ave ST. WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) widowed.

5a If married, widowed, or divorced, give name of HUSBAND or WIFE of Thomas Hinton

6 DATE OF BIRTH (month, day, and year) June 5-1846

7 AGE Years 75 Months 8 Days 6 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

10 NAME OF FATHER James Lloyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Ann Cantling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs. J. E. Hawkins (Address) 14 Strathmore Ave.

15 FEB 12 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1922, to Feb 11, 1922, that I last saw him alive on Feb 11, 1922, and that death occurred, on the date stated above, at 1 P. M. The CAUSE OF DEATH\* was as follows:

Cerebral Haemorrhage (duration) yrs. mos. ds. 20

CONTRIBUTORY Arterio Sclerosis (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Signs

(Signed) J. E. Hawkins, M. D.

(Address) 1301 N. Bal. Road.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Cemetery. 2/13/22

20 UNDERTAKER ADDRESS 1442

Robt. L. Turner, Inc. 2 Broadway





## HEALTH DEPARTMENT—CITY OF BALTIMORE 61218

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Landward* ST., *27* WARD)

## 2-FULL NAME

*Robert Warren Decus*

## (a) RESIDENCE NO.

*Belvedere*

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced. (write the word)*Male White**Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*July 23 1901*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*1 0**18*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*None*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

*None*9 BIRTHPLACE (city or town)  
(State or country)*Baltimore Md*

10 NAME OF FATHER

*Robert A Decus*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Baltimore Md*

12 MAIDEN NAME OF MOTHER

*Agnes Decus*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Baltimore Md*

14

Informant  
(Address)*Robert A Decus  
Landward*

15

Filed

*FEB 12 1922*

ROBERT R. KRAUTER,

Burial Permit Clerk.

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb 10 1922*

17

I HEREBY CERTIFY, That I attended deceased from  
*Feb 8 1922*, to *Feb 10 1922*.that I last saw him alive on *Feb 10 1922*,and that death occurred, on the date stated above, at *7 p. m.*

The CAUSE OF DEATH\* was as follows:

*Lobar pneumonia  
(Double)*(duration) *no* yrs. *no* mos. *7* ds.CONTRIBUTORY  
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

*Home*

Did an operation precede death?

*no*

Was there an autopsy?

*no*

What test confirmed diagnosis?

*Examination of*

(Signed)

*Thos. L. ... M. D.*

, 19

(Address)

*Landward*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL.

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

*Friendship Cemetery**W. L. ...**Feb 12 1922**North*

N. B.—WRITE PERMANENT, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCURRENCE IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61219

## CERTIFICATE OF DEATH.

170 D 61219

REGISTERED NO. C

### PLACE OF DEATH

CITY OF BALTIMORE (No. *3911 Towanda Ave.* ST. *15* WARD)

2-FULL NAME *Henry S. Davis.*

(Residence in Baltimore: No. *3911 Towanda Ave.*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

*30*  
St.: yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *married*  
(Write the word.)

6-DATE OF BIRTH, *Nov. 14, 1886*  
(Month) (Day) (Year)

7-AGE, *35*  
*36* yrs. *2* mos. *25* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *Furniture dealer*  
(b) General nature of industry, business, or establishment in which employed (or employer), *D.H.S.*

9-BIRTHPLACE, (State or Country), *Ind. Md.*

10-NAME OF FATHER, *Linbury Davis.*

11-BIRTHPLACE OF FATHER (State or Country), *Md.*

12-MAIDEN NAME OF MOTHER *Fleming Steele*

13-BIRTHPLACE OF MOTHER (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. H. S. Davis*

(Address) *3911 Towanda Ave.*

15- *FEB 12 1922* ROBERT R. KRAUTER

Filed *1922* Registrar

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb. 10, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry*  
(Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said *inquiry*  
(Inquest, au-  
topsy or inquiry.)  
and that said deceased came to *his* death  
on the day stated above.  
The CAUSE OF DEATH\* was as follows:

*Gun shot wound*  
*in head.*  
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *over*

(Signed) *J. T. Hennessy* M. D.  
(Coroner.)

*Feb 10, 1922* (Address) *3802 Eastman Ave.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the  
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Woodlawn Cem.* DATE OF BURIAL, *Feb 13 1922*

20-UNDERTAKER, *Wm. Beckner Sons* ADDRESS *North Pa*



with bullet wound through head.  
Self inflicted. Suicide

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges,*

*peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

*Abortion*, *Hæmorrhage*, *Meningitis*, *Phlebitis*,  
*Cellulitis*, *Gangrene*, *Miscarriage*, *Pyæmia*,  
*Childbirth*, *Gastritis*, *Necrosis*, *Septicæmia*,  
*Convulsions*, *Erysipelas*, *Peritonitis*, *Tetanus*.

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides*, *Homicides*, *Abortions (if induced)*, whether death is directly or indirectly due to same.



D 61220

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1130 D 61220

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *820 Milton Ave* ST. *4th* WARD)

## 2. FULL NAME

(a) RESIDENCE NO. *1820 N. Milton Ave* ST. *4th* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb. 7, 1922*

7 AGE

Years

Months

Days

If LESS than 1 day, —hrs. or min.

*4*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *Albert J. Chapman*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore*12 MAIDEN NAME OF MOTHER *Euna M. Wiley*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore*

14

Informant (Address)

*Albert J. Chapman*  
*1820 N. Milton Ave*

15

FEB 12 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 10, 1922*17 I HEREBY CERTIFY, that I attended deceased from *Feb. 7, 1922* to *Feb. 10, 1922*, that I last saw him alive on *Feb. 10, 1922*, and that death occurred, on the date stated above, at *10 P.* m.

The CAUSE OF DEATH\* was as follows:

*Intestinal Colic*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *2*(duration) yrs. mos. ds. *2*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *William F. Truett*  
4/11, 1922 Address) *1407 N. Bay St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Baltimore Cemetery*

DATE OF BURIAL

*Feb. 13, 1922*

20 UNDERTAKER

*George Schelling & Sons*

ADDRESS

*1126 E. Monument*

For information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61221

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *612 E 34<sup>th</sup>* ST., *9* WARD)

### 2-FULL NAME

*John W. Andrews*

(a) RESIDENCE NO. *612 E 34<sup>th</sup>*

(Usual place of abode)

Length of residence in city or town where death occurred *61* yrs. *9* mos. *30* ds.

ST.,

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Widower*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

*Anna W. Andrews*

6 DATE OF BIRTH (month, day, and year)

*April 12<sup>th</sup> 1860*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*61*

*9*

*30*

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Paying Teller*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Old Town Natl Bank*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md*

10 NAME OF FATHER

*S. Kennedy Andrews*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balto Md*

12 MAIDEN NAME OF MOTHER

*Julia A. De Matt*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Maryland*

14

Informant (Address)

*Mrs Mary Warner 612 E 34<sup>th</sup> St*

15

*FEB 12 1922*

*ROBERT H. KRAUTER,*

Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 11<sup>th</sup> 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 7<sup>th</sup> 1922* to *Feb 11 1922*,

that I last saw him alive on *Feb 11<sup>th</sup> 19*

and that death occurred, on the date stated above, at *530 P. m.*

The CAUSE OF DEATH\* was as follows:

*Right lobe pneumonia,*

(duration) yrs. mos. *4* ds.

CONTRIBUTORY

(Secondary) *Stenosis*

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Coxsacki & Wright*

(Signed)

*Oving Meier* M. D.

, 19

(Address)

*108 E. North Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

*Greenmount Cemetery*

DATE OF BURIAL

*Feb 18<sup>th</sup> 1922*

20 UNDERTAKER

*George Schilling & Sons*

ADDRESS

*1126 E. Mount St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61222

D 61222

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *2105 Atlantic ave* ST., *9* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

*Katherine E. Schisler*(a) RESIDENCE NO. *2105 Atlantic ave* ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *26* yrs. *7* mos. *18* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**White**Single*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *June 24<sup>th</sup> 1895*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.*26**7**18*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore**md*

10 NAME OF FATHER

*John H Schisler*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Harford Co md*

12 MAIDEN NAME OF MOTHER

*Linnie Scheffer*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Balto**md*

14

Informant  
(Address)*John H Schisler*  
*2105 Atlantic ave*

FEB 12 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 11<sup>th</sup> 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 2*, 1922, to *Feb 11*, 1922,that I last saw him alive on *Feb 10*, 1922,and that death occurred, on the date stated above, at *7:25 A. M.*

The CAUSE OF DEATH\* was as follows:

*Pulmonary Embolus*

(duration) yrs. mos. ds.

CONTRIBUTORY

*Acute Endocarditis and*  
*Blood stream infection (streptococcus)*  
(duration) yrs. mos. ds. *Viridans*18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis? *Blood culture positive*

(Signed)

*Chas. J. ...* M. D.F-412 1922 (Address) *4706 Harford Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL*Baltimore Cemetery*

DATE OF BURIAL

*July 18<sup>th</sup> 1922*

20 UNDERTAKER

*Georg Schilling & Sons*

ADDRESS

*1126 E. ...*

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE, 001 D 61223

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST.: 161 WARD)

WARD.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

FEB 12 1922

ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12, 1922

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on Feb 12, 1922, to Feb 12, 1922, at 9:15 A. M.

The CAUSE OF DEATH\* was as follows:

Prematurity

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wright 4 lbs

(Signed) Horace G. Stewart M. D.

12, 1922 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



D 61224

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61224

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hosp.* ST.: *9* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. *563 W. 159<sup>th</sup> St.* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *21* ds. How long in U. S., if of foreign birth? yrs. mos. *21* ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*M.*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced (write the word)

*married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*unknown*

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*47*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*unknown*

(b) General nature of industry, business, or establishment in which employed (or employer)

*087*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*unknown*

## 10 NAME OF FATHER

*unknown*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*unknown*

## 12 MAIDEN NAME OF MOTHER

*unknown*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*unknown*

## 14

Informant  
(Address)*Wm J. A. McHenry  
3800 Spring Garden St Phila*

## 15

Filed

*FEB 12 1922*

ROBERT R. KRAUTER,

Racial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2-11-1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb. 5, 1922, to Feb. 11, 1922,*that I last saw him alive on *Feb 11, 1922.*and that death occurred, on the date stated above, at *7:50 A* m.

The CAUSE OF DEATH\* was as follows:

*Myocardial Insufficiency*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)*Lobar Pneumonia*

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date of *—*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *F. C. Marino* M. D.19 (Address) *St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Philadelphia**Feb 12 1922*

## 20 UNDERTAKER

*Wm Cook*

## ADDRESS

*502 E North*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 61225 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 D 61225

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Kidd(a) RESIDENCE. No. Unknown

ST. \_\_\_\_\_ WARD. \_\_\_\_\_

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
----------------------	---------------------------------	---

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of  
-----6 DATE OF BIRTH (month, day, and year) 1847

7 AGE <u>74</u>	Years	Months	Days	If LESS than 1 day, hrs. or min.
		--	--	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,  
(State or country) Maryland10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown  
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)14 Informant Hospital Records,  
(Address) Municipal Hospital15 FEB 13 1922 ROBERT R. KRAUTER,  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11 19 22

17 I HEREBY CERTIFY, That I attended deceased from March 22, 19 20, to February 11, 19 22, that I last saw him alive on February 10, 19 22, and that death occurred, on the date stated above, at 8:45 A.M. The CAUSE OF DEATH\* was as follows:

Pneumonia(duration) yrs. mos. ds. 3CONTRIBUTORY  
(Secondary)Chronic Myocarditis(duration) 10 yrs. mos. ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? yes

What test confirmed diagnosis?

(Signed) Chas. H. Wells M. D.2/11/22 Address) Municipal Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Takton Ind.Feb. 15 19 22

20 UNDERTAKER

ADDRESS

Joseph B Cook1003 N. Falls

N. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR- TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61226

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1524 N. Fulton Ave. ST., 15 WARD)

### 2. FULL NAME

Sarah C. Wilson

### (a) RESIDENCE NO.

1524 N. Fulton Ave.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. 1 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 27" 1836

7 AGE Years Months Days If LESS than 1 day, hrs or min. 85 1 14

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER George C. Patterson

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Sarah C.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md. (State or country)

14 Informant Mrs. J. E. Bentley (Address) 1524 N. Fulton Av.e

15 FEB 13 1922 ROBERT R. KRAUTER, Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10" 19 22

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1921, to Feb. 10, 1922, that I last saw him alive on Feb. 10, 1922, and that death occurred, on the date stated above, at 9.50 P. m. The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis

(duration) 4 yrs. 2 mos. ds. CONTRIBUTORY (Secondary) Apoplexy (duration) 3 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

Signature J. M. Lempert M. D. Feb. 11, 1922 (Address) 826 N. Carrollton

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL DATE OF BURIAL

Not View Cemetery Maryland. Feb 14, 1922

20 UNDERTAKER ADDRESS

Joseph B. Cook 1003 N. Baltimore St.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 61227

D 61227

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 407 Maryland ST., 27 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ST., WARD

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 28 1847

7 AGE Years 74 Months 4 Days 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14 Informant (Address)

15

FEB 13 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1922 to Feb 11 1922 that I last saw him alive on Feb 10 1922 and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH\* was as follows:

Chronic Organic Heart Disease

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

20 UNDERTAKER

DATE OF BURIAL

ADDRESS



N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61228 HEALTH DEPARTMENT—CITY OF BALTIMORE 188.003 D 61228

CERTIFICATE OF DEATH.

(PLACE OF DEATH)

CITY OF BALTIMORE (NO.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.  
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

FEB 13 1922

191.

ROBERT R. KRAUTER,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

(Coroner)

191.

(Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs.... mos.... ds. In the State.... yrs.... mos.... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

*William Gilchrist included with Lecture  
for Gay St. at Falloway.*

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*,

*peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia," (merely symptomatic), "At-rophy," "Collapse," "Coma," "Convulsions," "De-bility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite dis-ease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septichæmia," "PUERP-ERAL peritonitis," etc. State cause for which sur-gical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Ex-amples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homi-cide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional in-formation which may give any of the following diseases, without explanation as the sole cause of death:

*Abortion*, *Hæmorrhage*, *Meningitis*, *Phlebitis*,  
*Cellulitis*, *Gangrene*, *Miscarriage*, *Pyæmia*,  
*Childbirth*, *Gastritis*, *Necrosis*, *Septicæmia*,  
*Convulsions*, *Erysipelas*, *Peritonitis*, *Tetanus*.

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved): *Suicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61229

## CERTIFICATE OF DEATH.

31 D 61229

### 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 Fir Lane ST., 11 WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Louisa Gertrude Baumloch

(a) RESIDENCE NO. 501 Fir Lane ST., 11 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Arthur C. Baumloch

6 DATE OF BIRTH (month, day, and year) Jan 10 1880

7 AGE Years 42 Months Days If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) York Co. Pa. (State or country)

10 NAME OF FATHER Kenny Schuman

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

York Co. Pa.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

York Co

14

Informant

(Address)

Arthur Baumloch  
501 Fir Lane

ROBERT R. KRAUTER,

Burial Permit Clerk,

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 1921, 1921, to Feb 12 1922.

that I last saw her alive on Feb 5 1922.

and that death occurred, on the date stated above, at 10-30 A.M.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physician

(Signed) Arthur C. Baumloch, M. D.

(Address) 3429 Chestnut Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral

DATE OF BURIAL

2-14 1922

20 UNDERTAKER

Wm Cook

ADDRESS

502 E North



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 61230

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: 3738 Reisterstown Road WARD 5

2-FULL NAME

(a) RESIDENCE NO. 3738 Reisterstown Road WARD 5

(Usual place of abode)

Length of residence in city or town where death occurred: 10 yrs. mos. ds. How long in U. S., if of foreign birth: 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male COLOR OR RACE White Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced, HUSBAND of Anna Katharine Schellhas (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 8 1857

7 AGE Years 64 Months 6 Days 6 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tin Smith

(b) General nature of industry, business, or establishment in which employed (or employer) Nurse

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

10 NAME OF FATHER H. W. Schellhas

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Anna

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant (Address) 3738 Reisterstown Road

FEB 15 1922

ROBERT R. KRAUTER,

Filed

19

Registrar

Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1922

17 I HEREBY CERTIFY, That deceased from Oct 17, 1921, to July 10, 1922,

that I last saw him alive on July 8, 1922,

and that death occurred, on the date stated above, at 6:25 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Gentry, M. D.

11, 1922 (Address) 677 N. Enoch

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOUNTAIN JULY 13 1922

UNDERTAKER

ADDRESS

William Baker & Son



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61231

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1824 N. Lafayette St. WARD)

2-FULL NAME

George R. Burnett

(a) RESIDENCE NO.

1824 N. Lafayette St.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Florence Burnett

6 DATE OF BIRTH (month, day, and year)

March 1842

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

79

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Olert. opp

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. md.

10 NAME OF FATHER

Daniel Burnett

11 BIRTHPLACE OF FATHER (city or town)

Balto.

(State or country)

md.

12 MAIDEN NAME OF MOTHER

Paraham Reed

13 BIRTHPLACE OF MOTHER (city or town)

Balto.

(State or country)

md.

14

Informant (Address)

Mr. T. Burnett 728 Lennox St.

15

Feb 13 1922 Burial Permit Clerk,

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 10, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 17, 1922, to Feb 10, 1922, that I last saw him alive on Feb 9, 1922

and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic myocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. G. Jones M. D.

4/1 1922 (Address) 728 N. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Mt. Olivet Mr. Cook, 5026 North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61232

## CERTIFICATE OF DEATH.

129 D 61232

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 Gough ST., 3 WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

(a) RESIDENCE NO. 1215 Gough ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Stewart

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 62 Months Days If LESS than 1 day, hrs or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland (State or country)

10 NAME OF FATHER William Glenn

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Edwin B. O'Leary (Address) 1215 Gough St

15 Filed FEB 13 1922 ROBERT H. KRAUTER, Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11, 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1922 to Feb. 11, 1922 that I last saw him alive on Feb. 11, 1922 and that death occurred, on the date stated above, at 5.30 P. M. The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urine & etc

(Signed) Eugene L. Passanun M. D. 212 22 (Address) Pen Hills - Phila

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL

DATE OF BURIAL

Cedar Hill Cemetery Feb 14 1922

20 UNDERTAKER

ADDRESS

William Cook 5078 North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61233

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 gutman ave. ST. 9 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Elizabeth Kraft(a) RESIDENCE. NO. 607 gutman ave. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 0 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced

(or) WIFE of

Earle Brooks Kraft6 DATE OF BIRTH (month, day, and year) Feb 6-18947 AGE Years Months Days If LESS than 1 day, hrs. or min.  
28 0 6

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) md.10 NAME OF FATHER James Thomas Goodrick11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) md.12 MAIDEN NAME OF MOTHER Mary Elizabeth Knight13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) md.14 Informant J. M. Freeman (Address) 2631 N. Calvert St.15 Feb 13 1922 19 W. M. Krauter

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1922

17 I HEREBY CERTIFY, That I attended deceased from

Feb 12 1922, to Feb 12 1922that I last saw her alive on Feb 12 1922and that death occurred, on the date stated above, at 1:40 P. M.

The CAUSE OF DEATH\* was as follows:

Post-partum Hemorrhage(duration) yrs. mos. 6 ds.CONTRIBUTORY 3 months miscarriage (Secondary)(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb 12 1922Was there an autopsy? noWhat test confirmed diagnosis? Phys. signs(Signed) J. M. Freeman, M. D.19 (Address) 2631 N. Calvert St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL 2-15 192220 UNDERTAKER Wm Cook ADDRESS 502 E. North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

61234

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 HOPKINS HOSPITAL.

ST.: 7 WARD)

2-FULL NAME Edward Brause

(a) RESIDENCE. NO. 1312 Randolph St NW

(Usual place of abode)

Washington DC

ST.,

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 11 1902

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

19

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Student

9 BIRTHPLACE (city or town) (State or country)

New York

10 NAME OF FATHER

Barnett Brause

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

de Francis Zappa

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant (Address)

HOPKINS HOSPITAL.

15

Informant (Address)

ROBERT R. KRAUTER

Burial Permit Clerk Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb. 8 1922, to Feb 11 1922,

that I last saw him alive on Feb 11 1922,

and that death occurred, on the date stated above, at 4 15 P. M.

The CAUSE OF DEATH\* was as follows:

Hemangioma brain Epilepsy

CONTRIBUTORY (Secondary)

(duration) 7 yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Nuburary

Did an operation precede death?

Yes Date of Feb 11 1922

Was there an autopsy?

Yes

What test confirmed diagnosis?

(Signed) Emil Holman, M. D.

19 (Address) Johns Hopkins Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

4 John Crossdale

2-13-1922

20 UNDERTAKER

ADDRESS

Jack Lewis, 1411 E. Balto



D 61235

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

138 D 61235

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital*)

WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Cynthia K. Hollingshead*

## (a) RESIDENCE. NO.

*1639 Clifton Ave.* ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*John J. Hollingshead*

6 DATE OF BIRTH (month, day, and year)

*3/14/1887*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*34**11**27*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Stewartstown Pa.*

10 NAME OF FATHER

*Thomas Gordon*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*ind*

12 MAIDEN NAME OF MOTHER

*Mary Finney*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Stewartstown Pa.*

14

Informant (Address)

*John J. Hollingshead 1539 Clifton Ave.*

15

FEB 13 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*2/10/1922*

17

I HEREBY CERTIFY, That I attended deceased from

*2/6/1922*, to *2/10/1922*, that I last saw him alive on *2/10/1922*and that death occurred, on the date stated above, at *6:05 P.M.*

The CAUSE OF DEATH\* was as follows:

*Myocardial Insufficiency*

CONTRIBUTORY (Secondary)

*Postoperative illness*

18 Where was disease contracted if not at place of death?

Did an operation precede death?

*Yes* Date of *2/7/22*

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Stewartstown Pa Feb 15, 22*

20 UNDERTAKER

ADDRESS

*George J. Smith 10002 Gay St.*

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as ~~probably~~ such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Operation for  
Tubo-ovarian abscess  
for years. Not luetic  
in origin. Streptococcus  
infection. Operation  
shock to heart.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 61236 HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Aged Women's Home* ST. *19* WARD)

2-FULL NAME

(a) RESIDENCE. No. *1400 W. Lexington* ST. *19* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *58* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*

4 COLOR OR RACE *W. H. T.*

5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *June 1852*

7 AGE

Years *69*

Months *8*

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *000*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *T. Baeco Co*

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER *Enoch E. Varnow*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore*

12 MAIDEN NAME OF MOTHER *Elizabeth A. Pichardt*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore*

14

Informant (Address) *Alfred J. Jones*

15

FEB 13 1922

ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 10 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*June 2, 1921*, to *Feb. 10, 1922*.

that I last saw h. alive on *Feb 9, 1922*.

and that death occurred, on the date stated above, at *815 A.* in.

The CAUSE OF DEATH\* was as follows:

*Organic Dis. Heart.*

CONTRIBUTORY (Secondary)

(duration) *1* yrs. mos. ds.

(duration) *2* yrs. mos. ds.

18 Where was disease contracted if not at place of death? *No*

Did an operation precede death? *No* Date of *11.6*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. M. D.*

(Address) *937 N. Fayette St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Western Cemetery Feb 13 1922*

20 UNDERTAKER

*George J. Smith*

ADDRESS *1000*

*H. Foye*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 61237 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

2-FULL NAME Adam C. Ritz

(a) RESIDENCE. No. Unknown

ST. 76 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 81 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto., Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) Municipal Hospital.

15 FEB 13 1922 ROBERT N. KRAUTER,

Deputy Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 10 1922

17 I HEREBY CERTIFY, That I attended deceased from February 7, 1922, to February 10, 1922.

that I last saw him alive on February 10, 1922.

and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH\* was as follows:

osteomyelitis right radius

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test (conduction) diagnosis?

(Signed) P. McNeill

M. D.

2/11/22 Address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Trinity Cem.

DATE OF BURIAL

2/13/22

20 UNDERTAKER

Geo A Farley Fulton & Son

ADDRESS

Trinity



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Cause unknown.*



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 61239 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1810 W. Lafayette Ave ST., 16 WARD)

2-FULL NAME Julia A. Mask.

1810 W. Lafayette Ave.

(a) RESIDENCE NO.

(Usual place of abode)

ST.,

WARD

Length of residence in city or town where death occurred

Lifes.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 ~~Single~~ Married, Widowed, Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Charles M. Mask

6 DATE OF BIRTH (month, day, and year) April 11th, 1850

7 AGE Years 71 Months -- Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

10 NAME OF FATHER Joseph Fuller

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Margaret Crone

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mrs Warren Stone

(Address)

1810 W. Lafayette Ave

15

FEB 13 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 5, 1922, to Feb 11, 1922.

that I last saw her alive on Feb 10, 1922.

and that death occurred, on the date stated above, at 1. a. m.

The CAUSE OF DEATH\* was as follows:

Apoplexy

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

W. E. Jones M. D.

711, 1922 (Address) 720 N North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Louisa Park Cemetery

20 UNDERTAKER

Centrambore

DATE OF BURIAL

Feb 13th, 22

ADDRESS

1810 W. Lafayette Ave

D 61240

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61240

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Med. Gen Hosp* ST.: *14* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Linda Lewis*

## (a) RESIDENCE, NO.

*706 W Lafayette Ave*

## WARD.

(If nonresident give city or town and State)

(Usual place of abode)  
Length of residence in city or town where death occurred

ds. How long in U. S., (if of foreign birth?) yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Nov 30 - 1856*

## 7 AGE

*65*

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*H-wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Home*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Balto Md*

## 10 NAME OF FATHER

*John Lewis*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Balto*

## 12 MAIDEN NAME OF MOTHER

*Rosa Alexander*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Balto*

## 14

Informant  
(Address)*Dr. R. H. Lewis  
706 W. Lafayette Ave*

## 15

Filed

FEB 13 1922

ROBERT A. KRAUSE  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/12/22*

## 17

I HEREBY CERTIFY. That I attended deceased from  
*2/4/22*, 19, to *2/12/22*, 19  
that I last saw him alive on *2/12/22*  
and that death occurred, on the date stated above, at *8:10 am*

The CAUSE OF DEATH\* was as follows:

*Cardiac insufficiency,  
pulmonary edema*CONTRIBUTORY  
(Secondary)(duration) yrs. mos. ds.  
*Mitral insufficiency + Bronchitis*  
(duration) yrs. mos. ds.  
*2 yrs*18 Where was disease contracted  
If not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

*Greenmount Cemetery  
Baltimore**Feb 14 1922  
1723 W. Lafayette Ave*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61241

## CERTIFICATE OF DEATH.

D 61241

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110-Montebello Terrace ST.: 27 WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

HENRY MESNER

(a) RESIDENCE. No. 110-Montebello-Terrace ST., 27 WARD. (Resident)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 3 mos. 16 ds. How long in U. S., if of foreign birth? 72 yrs. 3 mos. 16 ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Sophie Lillian Mesner.

6 DATE OF BIRTH (month, day, and year) October-27-1849

7 AGE Years 72 Months 3 Days 16 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grain Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Grain and Feed

(c) Name of employer (self) Henry Mesner & Son.

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland

10 NAME OF FATHER George Mesner

11 BIRTHPLACE OF FATHER (city or town) not known  
(State or country) Germany

12 MAIDEN NAME OF MOTHER Christianna Moser

13 BIRTHPLACE OF MOTHER (city or town) not known  
(State or country) Germany

14 Informant Edgar H. Mesner (son)  
(Address) 2619-Guilford Av., City.

15 Filed FEB 13 1922 ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1922, to Feb. 12, 1922

that I last saw him alive on Feb. 11, 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.  
Arthur Schuman  
(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Claus Schuman, M. D.

(Address) 4706 Hospital Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

GREEN MOUNT CEMETERY

Feb-15-22

20 UNDERTAKER

STEWART & MOWEN COMPANY  
(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

61242

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Glenmore &amp; Rockwood Aves ST. 27 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME BLANCHE LOUDEN MacCARTHY

(a) RESIDENCE No. Glenmore-Rockwood Aves. ST. 27 WARD. (Resident)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs ? mos ? ds. How long in U. S. If of foreign birth? 58 yrs 5 mos 24 ds

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of  
(Single)

6 DATE OF BIRTH (month, day, and year) August-18-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	5	24	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher in the

(b) General nature of industry, business, or establishment in which employed (or employer) Balt. Public School

(c) Name of employer City of Baltimore

9 BIRTHPLACE (city or town) Savage  
(State or country) Howard Co., Md.

10 NAME OF FATHER Florence Thomas MacCarthy

11 BIRTHPLACE OF FATHER (city or town) not known  
(State or country) not known

12 MAIDEN NAME OF MOTHER Anne White

13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country) Maryland14 Informant Howard MacCarthy (brother)  
(Address) Glenmore-Rockwood Av., City.

15 FEB 13 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/10 1922

17 I HEREBY CERTIFY, That I attended deceased from

Carr 2nd, 1922, to Feb 10, 1922

that I last saw her alive on Feb 10, 1922

and that death occurred, on the date stated above, at 12:45 a.m.

The CAUSE OF DEATH\* was as follows:

apoplexy

18 CONTRIBUTORY (Secondary) duration) yrs. 39 mos. ds. Kunenbogn

18 Where was disease contracted  
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? none

What test confirmed diagnosis?

(Signed) H. O. Grant, M. D.

, 19 (Address) 1207 Poplar Grove

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL  
Woodlawn Cemetery Feb-13-2220 UNDERTAKER STEWART & MOWEN COMPANY  
(WILLIAM F. WOODEN, Successor)ADDRESS  
108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-1-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61243

## CERTIFICATE OF DEATH.

185 D 61243

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital

ST. 26 WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Tilghman

(a) RESIDENCE. No. Unknown

ST.      WARD.     

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE Years 70 Months -- Days -- If LESS than 1 day, hrs. -- or min. --

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Chestertown,  
(State or country) Maryland

10 NAME OF FATHER H. Johnson

11 BIRTHPLACE OF FATHER (city or town) Chestertown,  
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Chestertown,  
(State or country) Maryland

14 Informant Hospital Records,  
(Address) Municipal Hospital,

15 Filed 19 ROBERT H. KRAUTER,  
Registrar

FEB 13 1922 Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10 19 22

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1919 to February 10, 1922, that I last saw her alive on February 10, 1922, and that death occurred, on the date stated above, at 8:00 P.M.

The CAUSE OF DEATH\* was as follows:

Traumatic gangrene of  
leg. over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. ds.

18 Where was disease contracted —  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Study  
(Signed) P. J. Brumback M. D.

2/11/22 Address Municipal Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Funeral Home Jan 14 1922

20 UNDERTAKER ADDRESS Funeral Home

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Fell out of bed.  
Probably due to fall.*



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

61244

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1106 N. Carey ST. 16 WARD)

2-FULL NAME

Mary Lavinia Anderson

(a) RESIDENCE. NO.

1106 N. Carey

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

85 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Caleb Dorey Anderson

6 DATE OF BIRTH (month, day, and year)

Jan 27, 1876

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

(55)

85

0

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

Self.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Benjamin Nicholson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Elizabeth Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

Caleb D. Anderson 1106 N. Carey

15

Filed FEB 13 1922

ROBERT M. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1922

17

I HEREBY CERTIFY, That I attended deceased from

Dec 1 1921, to Feb 10 1922,

that I last saw her alive on Feb 9 1922,

and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH\* was as follows:

Nephritis Chronic

(duration) yrs. 2 mos. 8 ds.

CONTRIBUTORY (Secondary)

Obstipation

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no

Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine & Physical

(Signed) William H. Wright, M. D.

(Address) 1209 Presbiterian

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

1/13 1922

20 UNDERTAKER

ADDRESS

Samuel T. Hensley, 5800

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 61245

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 61245

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 547 W. West ST. 21 WARD)

2. FULL NAME

George T. Lubber

(a) RESIDENCE NO.

547 W. West

ST. 21 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Lifelong

ds.

How long in U. S., if of foreign birth?

hrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Anna M. Lubber

6 DATE OF BIRTH (month, day, and year)

Oct. 10 1878

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

43

4

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Restaurant

(b) General nature of industry, business, or establishment in which employed (or employer)

043

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Balto.

md

10 NAME OF FATHER

John Lubber

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Matilda Sheppach

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Balto

md

14

Informant  
(Address)

John Lubber  
547 W. West St

15

ROBERT R. KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 11 1922

17

I HEREBY CERTIFY, that I attended deceased from

Feb 5 1922 to Feb 11 1922

that I last saw him alive on Feb 10 1922

and that death occurred, on the date stated above, at 12:12 A.M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration)

hrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

hrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? NO Date of ✓

Was there an autopsy? NO

What test confirmed diagnosis? Clinical

(Signed) M. B. Smulinger M.D.

Address 682 Cheltenham Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral Cemetery

Feb 14 1922

20 UNDERTAKER

ADDRESS

James Dignan & Son

1000 S. Paca

FEB 13 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61246

## CERTIFICATE OF DEATH.

D 61246

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. *818 Homestead St.* ST.: *9* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Laurie Disney*(a) RESIDENCE No. *818 Homestead St.* ST.: *9* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Married.*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *George Disney*6 DATE OF BIRTH (month, day, and year) *September 27/59*7 AGE Years *63* Months *4* Days *15* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto* (State or country) *md*10 NAME OF FATHER *John Harrell*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Laurie Gunders*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)14 Informant *George Disney* (Address) *818 Homestead St.*15 Filed *FEB 13 1922* 19 *ROBERT R. KRAUTER* Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *February 11/22* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *January 8/22*, 19 *22*, to *Feb 11/22*, 19 *22*, that I last saw him alive on *Feb 11/22*, 19 *22*and that death occurred, on the date stated above, at *6.4* m.

The CAUSE OF DEATH\* was as follows:

*Acute Cordian Dilatation*

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Physical Exam*  
(Signed) *George H. D. M.D.*3/1/1922 Address) *401 E 25th St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park Cemetery**Feb 15 1922*

20 UNDERTAKER

ADDRESS

*John F. Disney**715 Light St*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

61247

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PLACE OF DEATH  
CITY OF BALTIMORE (No. *St. Elizabeths Home Chestnut Hill Ave* ST. *9* WARD)  
FULL NAME *William Lynn Williams*  
(Residence in Baltimore: No. *St. Elizabeths Home - Chestnut Hill Ave* St. *9* yrs. *8* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *black* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)  
6 DATE OF BIRTH *Unknown* (Month) *1* (Day) (Year)  
7 AGE *8* yrs. *8* mos. *1* ds. or min.?  
8 OCCUPATION *Committed to St. Elizabeths Home by Judge Williams Juvenile Court Feb 9, 1922*  
9 BIRTHPLACE (State or country) *Baeto. Md.*

PARENTS  
10 NAME OF FATHER *Could not obtain*  
11 BIRTHPLACE OF FATHER (State or country) *" "*  
12 MAIDEN NAME OF MOTHER *" "*  
13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

FEB 13 1922

ROBERT R. KRAUTER,

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *February 11, 1912*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY. That I attended deceased from *February 10, 1912* to *1912* that I saw him alive on *February 10, 1912* and that death occurred, on the date stated above, at *6 A.* m. The CAUSE OF DEATH\* was as follows:

Contributory (SECONDARY) *Concussion Heart Disease*  
(Duration) yrs. mos. ds.

(Signed) *Frank J. Ayer* M. D.  
*Feb 11, 1912* (Address) *2005 E. Monument St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. *2* ds. In the State yrs. *8* mos. *1* ds.  
Where was disease contracted?  
If not at place of death?  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Commissioner Health,*

FEB 1 1922



HEALTH DEPARTMENT—CITY OF BALTIMORE **D 61248****D 61248**

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Seegers(a) RESIDENCE. No. 215 N. Stricker St ST. 19 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of -----6 DATE OF BIRTH (month, day, and year) 18817 AGE Years 42 Months -- Days -- If LESS than 1 day, hrs. -- or min. --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)14 Informant Hospital Records, (Address) Municipal Hospital.15 Filed FEB 13 1922 ROBERT R. KRAUTER, Registrar

20 UNDERTAKER

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mount Olivet Feb. 13 1922John Mitchell ADDRESS 1201 N. Fayette16 DATE OF DEATH (month, day, and year) Feb. 11 19 22

17

I HEREBY CERTIFY, That I attended deceased from February 2, 19 22, to February 11 19 22, that I last saw her alive on February 11, 19 22, and that death occurred, on the date stated above, at 10:15 A.M.

The CAUSE OF DEATH\* was as follows:

Bilateral Carcinomatosis of  
ovaries - with Metastases to  
abdominal viscera

(duration) yrs. mos. ds.

CONTRIBUTORY Int. Obstruction + Cachexia (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ---

Was there an autopsy?

What test confirmed diagnosis? Chemical findings (Signed) L. H. Brumbaugh M. D.2/11/22 Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

D 61249

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 John St. ST. 11 WARD)

2. FULL NAME *Minnie C. Eader*

(a) RESIDENCE NO. 1310 John St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. 9 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed or divorced

(HUSBAND of) *Raymond R. Eader*  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Mar 2-1893*7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*28 9 10*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto*  
(State or country) *md*10 NAME OF FATHER *Wm. Gann*11 BIRTHPLACE OF FATHER (city or town) *Germany*  
(State or country)12 MAIDEN NAME OF MOTHER *Elizabeth Bergen*13 BIRTHPLACE OF MOTHER (city or town) *Balto*  
(State or country) *md.*14 Informant *Raymond R. Eader*  
(Address) *1310 John St.*15 *ROBERT R. KRAUTER*  
Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 12, 1922*17 I HEREBY CERTIFY, That I attended deceased from *Feb. 9, 1922* to *Feb. 12, 1922*  
that I last saw him alive on *Feb. 11, 1922*and that death occurred, on the date stated above, at *6:30 A. M.*

The CAUSE OF DEATH\* was as follows:

*Influenza*CONTRIBUTORY *Child birth*  
(Secondary) (duration) yrs. mos. ds. *4*(duration) yrs. mos. ds. *7*

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Geo. M. Kieffer*, M. D.  
(Address) *Moreland Park md*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Western Cemetery Feb. 14, 1922*

20 UNDERTAKER

ADDRESS

*John Outchell 1201 W. Fayette St.*MARGIN RESERVED FOR BINDING  
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.Filed  
FEB 13 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

61250  
Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

61250

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1312 N. Mulberry ST.; 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy Jane Gadsby Wallach

(a) RESIDENCE. NO. 1312 N. Mulberry ST., 19 WARD.  
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) single  
6 If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) Unknown  
7 AGE Years 79 Months \_\_\_\_\_ Days \_\_\_\_\_ If LESS than 1 day, hrs. or min. \_\_\_\_\_

8 OCCUPATION OF DECEASED  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) (State or country) Texas

10 NAME OF FATHER William Douglas Wallach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wash. D.C.

12 MAIDEN NAME OF MOTHER Margaret Chapman Newton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wash. D.C.

14 Informant Rosa L. Wallach  
(Address) 1312 N. Mulberry

15 FEB 13 1922 ROBERT R. KRAUTER,  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 12 1922

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1917, to February 12, 1922, that I last saw her alive on February 11, 1922, and that death occurred, on the date stated above, at 3:45 A. m.  
The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis & Chronic Interstitial Nephritis  
(duration) 5 yrs. mos. ds.

CONTRIBUTORY Hemiplegia (Left)  
(Secondary) (duration) 4 yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of \_\_\_\_\_

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination  
(Signed) J. W. Clift M. D.

112, 1922 (Address) 1312 N. Mulberry St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mount Olivet Cem. Feb. 14 1922  
20 UNDERTAKER John D. Mitchell ADDRESS 1201 N. Broadway

D 61251

HEALTH DEPARTMENT—CITY OF BALTIMORE D 61251

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *507 E Gittinggo* ST., *24* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Kenneth J. Yergens*

## (a) RESIDENCE NO.

*507 E Gittinggo*ST., *24* WARD

(Usual place of abode)

(If non-resident give city or town and State) •

Length of residence in city or town where death occurred — yrs. *2* mos. *27* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Nov 16 1921*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*2 27*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md*

## 10 NAME OF FATHER

*Carroll E Yergens*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Indiana*

## 12 MAIDEN NAME OF MOTHER

*Viola Wentworth*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore Md*

## 14

Informant (Address)

*Viola Wentworth 507 E Gittinggo St*

## 15

Filed

*FEB 13 1922*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 12 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*2/10*19*22*, to*2/12*19*22*.

that I last saw him alive on

*2/12*19*22*.

and that death occurred, on the date stated above, at

*5:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Convulsions Infantile*

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *no*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *J. E. Smith* M. D.Address *910 Light St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

*Cedar Hill Cemetery**Feb 13 1922*

## 20 UNDERTAKER

## ADDRESS

*John P. Denny**715 Light St*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for inalignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Cause unknown.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61252

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1532 D. Charles ST., 72 WARD)

## 2. FULL NAME

Eugene Eastman Burton

## (a) RESIDENCE NO.

1532 D. Charles ST.,

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8/19/187 AGE Years 3 Months 6 Days 8 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

FEB 13 1922

ROBERT R. KRAUTER

Registrar Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 192217 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1922, to Feb 11, 1922, that I last saw him alive on Feb 11, 1922, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH\* was as follows:

Cranial Encephalitis(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Campbell, M. D.(Address) 1644 Hancock

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

John J. Fahy, Inc.1314 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN,

*No infection prior*

WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

*Peter Saverio Sario*  
HEALTH DEPARTMENT—CITY OF BALTIMORE  
D 61253 CERTIFICATE OF DEATH. REGISTERED NO. C

1-PLACE OF DEATH  
CITY OF BALTIMORE (No. *204 N. Green St.* ST. *4* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
2-FULL NAME *Peter Saverio Sario*  
(Residence in Baltimore: No. *New York City N. Y.* St.: yrs. mos. *7* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *male* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*  
6-DATE OF BIRTH. *April 10, 1876*  
7-AGE. *45* yrs. mos. da. If LESS than 1 day, ... hrs. or ... min.  
8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *Shoemaker*  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Italy*

10-NAME OF FATHER, *Bersilio Sario*  
11-BIRTHPLACE OF FATHER (State or Country), *Italy*  
12-MAIDEN NAME OF MOTHER, *Not Known*  
13-BIRTHPLACE OF MOTHER (State or Country), *Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Samuel Miceli*  
(Address) *204 N. Green St.*

15- *FEB 13 1922* ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Feb 12, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, and from the evidence obtained by said inquest, and that said deceased came to death on the day stated above.  
The CAUSE OF DEATH\* was as follows:

*Regular disease of the heart*  
(Duration) yrs. mos. da. *not known*

CONTRIBUTORY (Secondary)

(Signed) *W. M. Roulton* M. D. (Coroner.)  
*2-13, 1922* (Address) *117 W. Verano St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. mos. da. In the State... yrs. mos. da.  
Where was disease contracted, if not at place of death?

Former or usual residence *New York City*

19-PLACE OF BURIAL OR REMOVAL. *Cathedral Cemetery* DATE OF BURIAL. *Feb. 13, 1922*

20-UNDERTAKER. *W. M. Roulton* ADDRESS. *230 N. Green*



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61254

## CERTIFICATE OF DEATH.

Registered No. C.....

### 1-PLACE OF DEATH

City of BALTIMORE: (No. *Franklin General Hospital* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### 2-FULL NAME

(Residence in Baltimore: No. *221 S. Pulaski* St.; yrs. *59* mos. .... ds.)

*Henry Fuller*

*221 S. Pulaski*

St.; yrs. *59* mos. .... ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*mal*

4-COLOR OR RACE,

*white*

5-Single,

*Married*  
Widowed,  
or Divorced,  
(Write the word.)

6-DATE OF BIRTH,

*Oct.*

*4*

*1862*

(Month)

(Day)

(Year)

7-AGE,

*59*

yrs.

*4*

mos.

*7*

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

*Bread Baker*

(b) General nature of industry, business, or establishment in which employed (or employer).

*Columbia Bakery*

9-BIRTHPLACE,

(State or Country).

*Balt. City*

10-NAME OF FATHER,

*Lewis Fuller*

11-BIRTHPLACE OF FATHER,

(State or Country).

*Germany*

12-MAIDEN NAME OF MOTHER,

*Katherine Hoban*

13-BIRTHPLACE OF MOTHER,

(State or Country).

*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Lisette Fuller*

(Address)

*221 S. Pulaski St.*

FEB 13 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Feb.*

*11*

*1922*

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*, au-

topsy or inquiry, and that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Bullet wound*  
*Brain self inflicted*  
*suicide*

CONTRIBUTORY (Secondary)

*Brain*

(Signed) *James M. Thompson*

(Coroner)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death *Franklin General Hospital* yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

*221 S. Pulaski St.*

Former or usual residence *221 S. Pulaski*

19-PLACE OF BURIAL OR REMOVAL

*London Park*

20-UNDERTAKER

*George H. Schwab*

DATE OF BURIAL

*Feb. 14*

1922

ADDRESS

*200 E. Chase St.*

D 61255

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61255

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. *16* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Ben Groszkoff*

## (a) RESIDENCE

No. *3738*

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *20* yrs. *1* mos. *18* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Single*

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Dec. 23/1901*

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*20**1**18*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Plaster 057*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Benj. Schultz*9 BIRTHPLACE (city or town)  
(State or country)*Leitz*

## 10 NAME OF FATHER

*Geo. Groszkoff*

## 11 BIRTHPLACE OF FATHER (city or town)

*Leiz*

(State or country)

## 12 MAIDEN NAME OF MOTHER

*Margaret Bennett*

## 13 BIRTHPLACE OF MOTHER (city or town)

*Md.*

(State or country)

## 14

Informant

(Address)

*Margaret Groszkoff*  
*3738 Gough St.*

## 15

Filed

FEB 13 1922

Burial Permit *1000*

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*Feb. 11 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*Feb. 10, 1922, to Feb. 11, 1922.*that I last saw him alive on *Feb. 11, 1922.*and that death occurred, on the date stated above, at *6 A* m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary Edema*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)*Myocardial Infarct*

(duration) yrs. mos. ds.

18 Where was disease contracted  
If not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Herman J. Dorf* M. D.19 (Address) *St. Joseph's Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Oak Lawn**Feb. 14 1922*

## 20 UNDERTAKER

## ADDRESS

*Philip Herwig**2016**Baltimore*

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61256

HEALTH DEPARTMENT—CITY OF BALTIMORE

61256

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

12-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

ROBERT R. KRAUTER,

Burial Permit Clerk,

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry,

thereon and from the evidence obtained by said inquest, au-

opsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

1st & 2nd degree burns

1st & 2nd degree burns

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D. (Coroner)

Feb. 11, 1922 (Address) 202 E. Baltimore St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death, yrs. mos. ds. State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Oak Lane

20-UNDERTAKER

Philip Herwig

DATE OF BURIAL,

Feb. 14, 1922

ADDRESS

2016 Orleans

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61257 HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

160  
REGISTERED NO. C

D 61257

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

715 N. Collington Ave. ST. 7

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Bob, Muth

(Residence in Baltimore: No.

715 N. Collington Ave.

St.: yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

Single

6-DATE OF BIRTH

January 11, 1922  
(Month) (Day) (Year)

7-AGE

1 yrs. 1 mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

None

ood

9-BIRTHPLACE  
(State or country)

Honolulu, Hawaii  
Bolt md.

PARENTS

10-NAME OF FATHER

Marcus Muth

11-BIRTHPLACE OF FATHER  
(State or country)

Bolt md.

12-MAIDEN NAME OF MOTHER

Emilia Mortensen

13-BIRTHPLACE OF MOTHER  
(State or country)

Bolt md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Milton Muth

(Address)

715 N. Collington Ave.

15-

Filed

FEB 13 1922

192

ROBERT B. KRAUTER,

REGISTRAR  
Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Feb 11, 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Bolt, 191, to, Feb 11, 1922

that I saw him alive on Feb 11, 1922

and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH\* was as follows:

Marasmus

(Duration) yrs. mos. ds

Contributory  
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed),

J. H. Vetter

M. D.

Feb 11, 1922 (Address) 508 E. North Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Oak Lawn

DATE OF BURIAL

Feb 14, 1922

20-UNDERTAKER

Philip Hennig

ADDRESS

2016



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61258

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2020 Ellsworth ST., 8 WARD)

## 2-FULL NAME

Maurice Knauer

## (a) RESIDENCE No.

2020 Ellsworth ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

7 mos.5 ds.

How long in U. S., if of foreign birth?

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

July 7 1921

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

75

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

ooo

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

## 10 NAME OF FATHER

Maurice Knauer

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Md.

## 12 MAIDEN NAME OF MOTHER

Elena Rohlinghoff

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Md.

## 14

Informant (Address)

Mr. Maurice Knauer  
2020 Ellsworth St.

## 15

ROBERT R. KRAUTER,

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb. 12 1922

## 17

I HEREBY CERTIFY, That I attended deceased from Feb. 9th 1922 to Feb. 12th 1922, that I last saw him live on Feb. 12th 1922 and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH\* was as follows:

Ischaemic Cerebral

(duration)

yrs.

mos.

ds.

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1901 E. Eager St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## 20 UNDERTAKER

## DATE OF BURIAL

## ADDRESS

Trinity CemeteryHenry HorckFeb. 18, 221301 E. Eager St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 61259

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61259

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *712 Arlington Ave. Severn* ST., *74* WARD)

## 2-FULL NAME

*Alice Leese*(a) RESIDENCE No. *712 Arlington Ave. Severn* ST., *74* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *25* yrs. *—* mos. *—* ds. How long in U. S., if of foreign birth? *25* yrs. *—* mos. *—* ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*5a If married, widowed, or divorced HUSBAND of *Robert J. Leese* (or) WIFE of *Alice Leese*6 DATE OF BIRTH (month, day, and year) *Sept. 12 1861*7 AGE Years *60* Months *5* Days *—* If LESS than 1 day, *—* hrs. or *—* min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*(b) General nature of industry, business, or establishment in which employed (or employer) *—*(c) Name of employer *—*9 BIRTHPLACE (city or town) *Balls Bl. Co.* (State or country) *Md.*10 NAME OF FATHER *Mr. Kroh*11 BIRTHPLACE OF FATHER (city or town) *Not Known* (State or country) *—*12 MAIDEN NAME OF MOTHER *Not Known*13 BIRTHPLACE OF MOTHER (city or town) *Not Known* (State or country) *—*14 Informant *M. M. P. Leese* (Address) *712 Arlington Ave. Severn*15 Filed *FEB 10 1922* *ROBERT R. KRAUTER* Burial Permit *—*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 12 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan. 25 1922* to *Feb. 12 1922* that I last saw her alive on *Feb. 12 1922*and that death occurred, on the date stated above, at *11:30 P.M.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Apoplexy.*(duration) *—* yrs. *—* mos. *12* ds.

## CONTRIBUTORY (Secondary)

(duration) *—* yrs. *—* mos. *—* ds.18 Where was disease contracted if not at place of death? *—*Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Flournoy M. D.* *3/13 1922* (Address) *401 E 25 St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Woodlawn Cemetery* DATE OF BURIAL *Feb. 13 1922*20 UNDERTAKER *Henry Hoeck Son* ADDRESS *1301 E. Eager St.*

N.B.—WRITE PLAINLY, WITH CARE AND IN INK. THIS IS A PERMANENT RECORD. Every statement should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61260

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO

ST.

WARD)

## 2-FULL NAME

(a) RESIDENCE. NO

(Usual place of abode)

Length of residence in city or town where death occurred

56 yrs.

mos.

ds. How long in U. S., if of foreign birth?

56 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Adel Samuel

6 DATE OF BIRTH (month, day, and year)

Sept - 1835

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

86

5

-

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired 143

(b) General nature of industry, business, or establishment in which employed (or employer)

liquor

(c) Name of employer

merchant.

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Nathan Samuel

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

S. Eichberg 1605 N. Mohr St

15

FEB 13 1922

ROBERT R. KRAUTER,  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/12/22

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Catastrophic Bronchitis (duration) 10 ds.

CONTRIBUTORY (Secondary)

Hypertension (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S. R. Hawk M. D.

19 (Address) 1424 N. Morton

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Balto. Heb. Cem. 2/14 1922

20 UNDERTAKER

David Sondheim 118 Mt. Royal Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61261

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or Country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed: FEB 13 1922 191. ROBERT H. KRAUTER, Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereon and from the evidence obtained by said

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

(Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death.... yrs.... mos.... ds. State.... yrs.... mos.... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS



MORE  
129 ✓ D 61262

**CERTIFICATE OF DEATH.**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(b) RESIDENCE No. 602 N 1<sup>st</sup> Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-2-22<sup>th</sup> 1922

17

I HEREBY CERTIFY, That I attended deceased from  
Sept, 1916, to Dec 11th, 1922.

that I last saw him alive on Feb 11th, 1922

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

Chronic Myocarditis  
Artero-Sclerosis

(duration) 10 yrs. 0 mos. 0 ds.

CONTRIBUTORY Branchio-Pneumonia  
(Secondary)

..... (duration) ..... yrs. .... mos. 10 ds.

18 Where was disease contracted  
if not at place of death? Secondary yes 14

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis: Physical Examination

(Signed) Franklin B. Anderson M. D.

19 (Address) 10 E. Benton St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL	DATE OF BURIAL

Baltimore. Feb. 15 1922

<b>20 UNDERTAKER</b>	<b>ADDRESS</b>
----------------------	----------------

Wm Cook. 502 E. 7<sup>th</sup>.

Dr. Anderson (Sommerlohn 13eda)

D 61263

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 D 61263

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

3308 Fleet

ST.: 46 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Margaret Challenor

## (a) RESIDENCE. NO.

3308 Fleet

ST.: 26 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

white

## 5 Single, Married, Widowed, or Divorced (write the word)

Widow

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

George G. Challenor

## 6 DATE OF BIRTH (month, day, and year)

Unknown

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

64

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

domestic work

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore Md

## 10 NAME OF FATHER

James Powers

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Baltimore Md

## 12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Baltimore Md

## 14

Informant

(Address)

Mrs Ella E. Stack  
3308 Fleet St

## 15

Filed

FEB 13 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 15, 1922, to Feb 12, 1922,

that I last saw her alive on Feb 10, 1922,

and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

Dilated heart

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. C. M. D.

1922 (Address) 839 O. Ellwood Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Carmel

## DATE OF BURIAL

2-15 1922

## 20 UNDERTAKER

Wm Cook

## ADDRESS

502 E. North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

VD 61265

D 61265

## CERTIFICATE OF DEATH.

31  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 W. Lombard ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 424 W. Lombard St.; 5 yrs.  mos.  ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 2-SEX

Female

## 4-COLOR OR RACE

Colored5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)  
Widow

## 6-DATE OF BIRTH,

unknown 1885  
(Month) (Day) (Year)

## 7-AGE,

27 yrs.  mos.  ds.If LESS than 1 day,  
....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,  
(State or Country),VA

## 10-NAME OF FATHER,

Lucas Gordon11-BIRTHPLACE OF FATHER  
(State or Country),VA

## 12-MAIDEN NAME OF MOTHER

Ann Eley13-BIRTHPLACE OF MOTHER  
(State or Country),VA

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert P. Harrison(Address) 406 W. Conway St.

15-

Filed Robert P. Harrison,  
191  Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

July 10 1914  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

July 10 1914, to July 10 1914,that I saw him alive on July 10 1914,and that death occurred, on the date stated above, at 39 m.

The CAUSE OF DEATH\* was as follows:

Leukemia  
(Duration)  yrs.  mos.  ds.CONTRIBUTORY (Secondary) unknown(Duration)  yrs.  mos.  ds.(Signed) W. H. Conner M. D.July 13, 1914 (Address) 109 W. Lombard

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Suffolk Va

DATE OF BURIAL,

7/13, 1914

20-UNDERTAKER

Mrs. H. H. Hooper

ADDRESS

406 W. Conway

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E8 13 1922 Burial Permit Work.



D 61266

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61266

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *836 S. Glenwood Ave.* ST.: *1* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Ann Joyant.*(a) RESIDENCE. No. *836 S. Glenwood Ave.* ST.: *1* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *70* yrs. mos. ds. How long in U. S., if of foreign birth? *70* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White.*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Widow.*

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Alexander Joyant.*6 DATE OF BIRTH (month, day, and year) *July 10-1854*

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*87*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Housework*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)*at home*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Ireland.*

## 10 NAME OF FATHER

*John Pike*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Ireland*12 MAIDEN NAME OF MOTHER *Ann Finney*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Ireland.*

## 14

Informant  
(Address)*Mary Friess  
836 S. Glenwood Ave.*

## 15

Signature

*Robert P. Harrison,*

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 11 1922*17 I HEREBY CERTIFY, That I attended deceased from  
*Jan 15*, 1922, to *Feb 11*, 1922,that I last saw him alive on *Feb 10*, 1922,and that death occurred, on the date stated above, at *8.30* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Pulmonary Nephritis*CONTRIBUTORY  
(Secondary)(duration) *1* yrs. mos. ds.(duration) *1* yrs. mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*W. L. King* M. D.  
*4/2, 1922* (Address) *1711 Eastern Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Oak Lawn Cem.*

## DATE OF BURIAL

*Feb. 14 1922*

## 20 UNDERTAKER

*Pilly & Zeller*

## ADDRESS

*403 S. Myrtle*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1848 1922

Physicians should state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D 61267

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ✓ D 61267

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3776 O'Donnell St. ST., 26 WARD)

2-FULL NAME

Elizabeth T. Fischer.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

3776 O'Donnell St.

ST., 26 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Edward A. Fischer

6 DATE OF BIRTH (month, day, and year)

Sept. 8 - 1897

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

24

5

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore  
Md.

10 NAME OF FATHER

Joseph Summer

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Balto  
Md.

12 MAIDEN NAME OF MOTHER

Lena Horn

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Balto  
Md.

14

Informant  
(Address)

Edward A. Fischer  
3776 O'Donnell St.

15

Signature

Ed. A. Fischer

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 10 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov 1, 1921, to Feb 10, 1922

that I last saw her alive on

Feb 9, 1922

and that death occurred, on the date stated above, at

1450 m.

The CAUSE OF DEATH\* was as follows:

Phtisic Pulmonary

(duration)

yrs.

6 mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

(if not at place of death?)

unknown

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical

(Signed)

W. H. McAvoy, M. D.

Feb 11, 1922 (Address)

839 D. Ellwood Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Sacred Heart Cem.

20 UNDERTAKER

Lilly and Zeller

DATE OF BURIAL

Feb. 13 1922

ADDRESS

403 S. Mifflin

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D 61268

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61268

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1614 E. 28<sup>th</sup> St.*)

2-FULL NAME

(Residence in Baltimore: No. *1614 E. 28<sup>th</sup> St.*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

*3* yrs., *0* mos., *0* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE

*White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED

*Married*  
(Write the word)

6-DATE OF BIRTH

*March 27, 1895*  
(Month) (Day) (Year)

7-AGE

*26* yrs., *10* mos., *12* da.  
If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

*Embroiderer, Steiner*  
*Ornamental Inc. Co.*

9-BIRTHPLACE

(State or Country)

*Balto Co. Md*

PARENTS.

10-NAME OF FATHER

*August Ludorf*

11-BIRTHPLACE OF FATHER

(State or Country)

*Germany*

12-MAIDEN NAME OF MOTHER

*Rosina Herbert*

13-BIRTHPLACE OF MOTHER

(State or Country)

*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Marie Von Rintelen (Sister)*

(Address)

*1614 E. 28<sup>th</sup> St*

15-

Filed

*Robert P. Harrison,*

191

Registrar.

*Burial Permit*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

*Feb. 11, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Pulmonary Congestion.*

(Duration) .... yrs. .... mos. .... da.

CONTRIBUTORY (Secondary)

*Heart Failure*

(Duration) .... yrs. .... mos. .... da.

(Signed) *J. K. G. M. D.*

*2-13-22* Address *Courier, 3, 5, 7, 9*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... da. State .... yrs. .... mos. .... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

*Sacred Heart Cem.*

DATE OF BURIAL

*Feb. 14, 1922*

20-UNDERTAKER

*Lily Ann Ziehl*

ADDRESS

*1038 W. 1st St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61269

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2901 E. Jefferson St. ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Sebastian J. Voith

(a) RESIDENCE. NO. 2901 E. Jefferson St. 6 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Voith

6 DATE OF BIRTH (month, day, and year) July 20 - 1882

7 AGE Years 39 Months 6 Days 21 If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Ind. (State or country)

10 NAME OF FATHER Anthony J. Voith Balto. Ind. (State or country)

11 BIRTHPLACE OF FATHER (city or town) Balto. Ind. (State or country)

12 MAIDEN NAME OF MOTHER Mary Brozman Balto. Ind. (State or country)

13 BIRTHPLACE OF MOTHER (city or town) Balto. Ind. (State or country)

14 Informant Jennie Voith 2901 E. Jefferson St. (Address)

15 Attest Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1922

17 I HEREBY CERTIFY that I attended deceased from Jan 26 1922 to Feb 11 1922 that I last saw him alive on Feb 11 1922

and that death occurred, on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

CONTRIBUTORY (Secondary)

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed William J. Danel, M. D. 1922 13 22 401 E. Redwood St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Am.

DATE OF BURIAL

20 UNDERTAKER Lily and Zeiler.

ADDRESS

403 S. Wolfe St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

873

1922



B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

D 61270

CERTIFICATE OF DEATH

46 D 61270

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

311 S. Clinton

ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

FULL NAME

Anna Marie Kirsch

(Residence in Baltimore: No.

311 S. Clinton St.

Sr. 3 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

May

26

1886

(Month)

(Day)

(Year)

7 AGE

35

yrs.

8

mos.

4

ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Housework at home

9 BIRTHPLACE

(State or country)

Balto Co. Md.

10 NAME OF FATHER

John S. Dietz

11 BIRTHPLACE OF FATHER

(State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Bernadine Brocklage

13 BIRTHPLACE OF MOTHER

(State or country)

Balto Co Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Kirsch

(Address)

311 S. Clinton St

15

Robert P. Harrison,

Burial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb.

12

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov

1921

to,

Feb.

12

1921.

that I saw her alive on

Feb.

11

1921.

and that death occurred, on the date stated above, at

m.

The CAUSE OF DEATH\* was as follows:

Uterine Carcinoma

(Duration) yrs. 9 mos. ds

Contributory (SECONDARY)

General Metastasis

(Duration) yrs. mos. ds.

(Signed), Frank A. Slantz M. D.

Feb. 12, 1921 (Address) 3244 Eastern Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Sacred Heart Cem.

DATE OF BURIAL

Feb. 14 1922

20 UNDERTAKER

Lilly and Zieba

ADDRESS

403 S. Wolfe St



D 61272

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61272

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1616 Calver*)ST. *5*

WARD)

REGISTERED NO. C

2-FULL NAME

*Lucy Clark*(Residence in Baltimore: No. *1616 Calver*)

St.; yrs., mos. da.)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Female*

4-COLOR OR RACE,

*Colored*

5-SINGLE,

*MARRIED, Married*  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

....., *1*.....  
(Month) (Day) (Year)

7-AGE,

*41* yrs. .... mos. .... ds.

If LESS than 1 day,

.... hrs. or .... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....*Housework**037*9-BIRTHPLACE,  
(State or Country),*Baltimore md*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER  
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER  
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Brown*(Address) *1616 Calver St*

15-

*Robert P. Harrison,*

Filed..... 191.....

1922 Burial Permit Clerk.

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Feb. 11, 1912*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said.....  
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Myocardial Infarction*

(Duration) yrs. .... mos. .... ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. .... mos. .... ds.

(Signed) *G. O. Blader*

(Coroner.)

M. D.

191..... (Address) *1616 Calver St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. .... mos. .... ds. In the State.... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

*Laurel*

DATE OF BURIAL,

*Feb. 14, 1912*

20-UNDERTAKER

*John W. Henderson*ADDRESS *1502**E. Monument St*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

D 61273

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61273

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1413 Linden av. ST. 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1413 Linden av. St. 23 yrs.,    mos.,    da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, married  
(Write the word.)6-DATE OF BIRTH, May 20, 1898  
(Month) (Day) (Year)7-AGE, 24 yrs.,    mos.,    da. If LESS than 1 day,    hrs. or    min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, no paid occupation  
(b) General nature of industry, business, or establishment in which employed (or employer),   9-BIRTHPLACE, (State or Country), Baltimore, Md.PARENTS.  
10-NAME OF FATHER, Frank Ravelle  
11-BIRTHPLACE OF FATHER (State or Country), M. C.  
12-MAIDEN NAME OF MOTHER, Mary E. Ireland  
13-BIRTHPLACE OF MOTHER (State or Country), Md.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis H. Harrison (husband)(Address) 1413 Linden av.

15-

Filed Robert P. Harrison, Registrar.

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Feb. 12, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from about Jan. 10-1922, to Feb. 12 1922, that I saw h    alive on Feb. 11 1922, and that death occurred, on the date stated above, at 4:30 a.m.The CAUSE OF DEATH\* was as follows:  
Myocarditis from  
infected ear(Duration)    yrs.,    mos.,    da.CONTRIBUTORY Infected ear probably from  
(Secondary)(Duration) about 4 wks.  
   yrs.,    mos.,    da.(Signed) J. F. Stenmark M. D.Feb. 12, 1922 (Address) 2226 Harding

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death    yrs.,    mos.,    da. In the State    yrs.,    mos.,    da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Balto Cemetery Feb 14, 1922

## 20-UNDERTAKER ADDRESS

J. Ahrens & Co 1611 Madave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

13 1922



## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 61274

## CERTIFICATE OF DEATH.

162 D 61274

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 Lewiston Ave

ST. 27 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 3 Lewiston Ave

St.: — yrs., — mos. 9 hrs.

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

## 6-DATE OF BIRTH,

Feb

11

1922

(Month)

(Day)

(Year)

## 7-AGE,

9 hrs

If LESS than 1 day,

9 hrs. or... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

## 9-BIRTHPLACE, (State or Country),

Balt. City

## 10-NAME OF FATHER,

Arthur Farrow

## 11-BIRTHPLACE OF FATHER (State or Country),

Balt. Ind.

## 12-MAIDEN NAME OF MOTHER

Ollie Rill

## 13-BIRTHPLACE OF MOTHER (State or Country),

Balt. Co. Md

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Arthur Farrow

(Address)

3 Lewiston Ave

## 15-

Filed

Robert F. Harrison,

101

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Feb

11

1922

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

2-11 1922, to 2-11 1922

that I saw her alive on 2-11 1922,

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH\* was as follows:

Congenital Inanition

(Duration)..... yrs..... mos. 9 hrs.

## CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos. 9 hrs.

(Signed)..... C. B. Gussor..... M. D.

Feb. 12, 1922 (Address) 5016 Park Heights Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Cedar Hill Cem

## DATE OF BURIAL,

Feb. 13, 1922

## 20-UNDERTAKER

F. A. Krause &amp; Son

## ADDRESS

703 Hammer

Exact statement of OCCUPATION. Exact statement of DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

B 3 1922

3 1922

Burial Permit 61274

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE  
D 61275  
CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 539 M<sup>rs</sup>. Meehan St. 14 WARD)

2-FULL NAME David Brandis

(Residence in Baltimore: No. 539 M<sup>rs</sup>. Meehan St. 14 St.; yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male 4-COLOR OR RACE, colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, separated (Write the word.)

6-DATE OF BIRTH, Oct. 19, 1897 (Month) (Day) (Year)

7-AGE, 24 yrs. 3 mos. 22 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Elevator operator (b) General nature of industry, business, or establishment in which employed (or employer), 976

9-BIRTHPLACE, (State or Country), Virginia

10-NAME OF FATHER, Ed. Brandis

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Katie Baulty

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ed. Brandis

(Address) 539 M<sup>rs</sup>. Meehan St.

15- Robert P. Harrison,

19122 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 11, 1912 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above. The CAUSE OF DEATH\* was as follows:

Asphyxiation (Duration) 1 yrs. mos. ds. Fell against rock 2 yrs. ago.

CONTRIBUTORY (Secondary) (Duration) 1 yrs. mos. ds.

(Signed) J. H. Hennessey, M. D. (Coroner.)

Feb. 13, 1912 (Address) 2802 E. Baltimore

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. State... yrs. mos. ds.

Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Mt. Auburn Cemetery Feb. 14, 1912

20-UNDERTAKER, James H. Davis ADDRESS 1303 Chestnut

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61276

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William McDonough(a) RESIDENCE. No. 2938 E. Fayette St. ST.      WARD.       
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 18837 AGE Years Months Days If LESS than 1 day, hrs. or min.  
38 -- -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,  
(State or country) Maryland10 NAME OF FATHER William McDonough11 BIRTHPLACE OF FATHER (city or town) Balto.,  
(State or country) Maryland12 MAIDEN NAME OF MOTHER Mary Cornalley13 BIRTHPLACE OF MOTHER (city or town) Balto.,  
(State or country) Maryland14 Informant Hospital Records,  
(Address) Municipal Hospital.15 Filed Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10 19 2217 I HEREBY CERTIFY, That I attended deceased from February 6, 19 22, to February 10 19 22 that I last saw him alive on February 10, 19 22 and that death occurred, on the date stated above, at 7:30 P.M.  
The CAUSE OF DEATH\* was as follows:Lobar pneumonia(duration) yrs. mos. ds. 7

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. McNeill M. D.  
per J. A. Moran  
19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

New Baltimore 2-14-1922

20 UNDERTAKER

J. A. Moran ADDRESS 2000 E. Baltimore

Physician should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

B13 1922

Burial Permit Clerk.

D 61277

## HEALTH DEPARTMENT—CITY OF BALTIMORE, 06 61277

## CERTIFICATE OF DEATH.

REGISTERED NO. 74

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

20 yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

WARD.

(If nonresident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14 Informant (Address)

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1922, to Feb 11, 1922, that I last saw him alive on Feb 10, 1922, and that death occurred, on the date stated above, at P. M.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Feb 11 1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

EB 13 1922



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61278

D 61278

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *15 Duick Ave. Roseburg* ST. *101* WARD)

## 2. FULL NAME

*Joseph A. Chetelat*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

*15 Duick Ave. Roseburg*ST. *101* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sept 8th 1921*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *5 4*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Maryland*10 NAME OF FATHER *Henry A. Chetelat*11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country) *Maryland*12 MAIDEN NAME OF MOTHER *Elizabeth Scholtz*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)

## 14

Informant *Henry A. Chetelat* (Address) *15 Duick Ave. Roseburg*

B13 1922

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 13th* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from *Dec. 29th* 19 *21* to *Feb. 13th* 19 *22* that I last saw him alive on *Feb. 12th* 19 *22*and that death occurred, on the date stated above, at *15 Duick Ave.* m.

The CAUSE OF DEATH\* was as follows:

*Empyema*(duration) yrs. mos. ds. *45*

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *2/9/22*Was there an autopsy? *No*What test confirmed diagnosis? *Evidence before operation*(Signed) *A. L. Bullison* M. D.2/3, 1922 (Address) *Belwin Hotel*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

*Holy Redeemer Cemetery Feb. 10 1922*

## 20 UNDERTAKER

## ADDRESS

*Frank Lassman & Sons Fullerton Md*

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "*Laborer*," "*Foreman*," "*Manager*," "*Dealer*," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "*Epidemic cerebrospinal meningitis*"); *Diphtheria* (avoid use of "*Croup*"); *Typhoid fever* (never report "*Typhoid pneumonia*"); *Lobar pneumonia*; *Bronchopneumonia* ("*Pneumonia*," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "*Cancer*" is less definite; avoid use of

"*Tumor*" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "*Asthenia*," "*Anemia*" (merely symptomatic), "*Atrophy*," "*Collapse*," "*Coma*," "*Convulsions*," "*Debility*" ("*Congenital*," "*Senile*," etc.), "*Dropsy*," "*Exhaustion*," "*Heart failure*," "*Hemorrhage*," "*Inanition*," "*Marasmus*," "*Old age*," "*Shock*," "*Uremia*," "*Weakness*," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "*Contributory*." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

Probably pleural  
pneumonia.  
Not tuberculous.



D 61280

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61280

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 5206 Wayne Ave. ST. 28 WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 5206 Wayne Ave. ST. WARD

(Usual place of abode)  
Length of residence in city or town where death occurred 67 yrs. 10 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Alice G. Shutt

6 DATE OF BIRTH (month, day, and year) March 29-1854

7 AGE Years 67 Months 10 Days 14 If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)14 Informant  
(Address)

15

PHYSICIANS should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to Feb 12, 1922, that I last saw him alive on Feb 10, 1922, and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Stomach  
unknown  
(duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)18 Where was disease contracted  
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) C. S. Hubbert M. D.

(Address) 2220 Garrison

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
BURYAL

FUNERAL

Funeral Home  
Funeral Home

DATE OF BURIAL

Feb. 15 1922

ADDRESS

3631 Falls Rd

B 13 1922

Burial Form 100

Registrar



Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61281 HEALTH DEPARTMENT—CITY OF BALTIMORE 001 D 61281

CERTIFICATE OF DEATH.

1-PLACE OF DEATH  
CITY OF BALTIMORE (No. *Chickasaw* ST. WARD)  
2-FULL NAME *Mathews Cornejo*  
(Residence in Baltimore: No. *725 Hartford Ave*)

REGISTERED NO. C  
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
*35* St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>Male</i>	4-COLOR OR RACE, <i>col</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <i>Married</i> (Write the word.)
6-DATE OF BIRTH, (Month) (Day) (Year) <i>1</i>		
7-AGE, <i>61</i> yrs. mos. ds. If LESS than 1 day, ... hrs. or ... min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). <i>Domestic</i> <i>070</i>		
9-BIRTHPLACE, (State or Country), <i>md.</i>		
PARENTS.	10-NAME OF FATHER, <i>Unbrun</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>md</i>	
	12-MAIDEN NAME OF MOTHER <i>Unbrun</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>md</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) *Rev. J. B. Mathews*  
(Address) *643 Ensor St*

15-  
*Robert P. Harrison,*  
Filed *191* Registrar.  
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *Feb 11*, *1922*  
(Month) (Day) (Year)  
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, that said deceased came to death on the day stated above.  
The CAUSE OF DEATH was as follows:  
*Asphyxia*  
*Choked*  
*Blue and*  
(Duration) yrs. mos. ds.  
CONTRIBUTORY (Secondary) *Heart*  
(Signed) *M. J. M. D.*  
(Coroner.)  
*2-13, 1922* (Address) *4600*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  
18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).  
At place of death... yrs. mos. ds. In the State... yrs. mos. ds.  
Where was disease contracted, if not at place of death?  
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,  
*Laurel Cem* *Feb 14*, 1922  
20-UNDERTAKER ADDRESS  
*Jas H. Skinner #1625 C. Ind. St*



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61283

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 D 61283

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 2770 Fenwick Ave ST 9

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Wilde Bartlett

(Residence in Baltimore: No. 2770 Fenwick Ave St. 52 yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Divorced

6-DATE OF BIRTH Apr 27, 1869 (Month) (Day) (Year)

7-AGE 52 yrs. 10 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Hon Molder (b) General nature of industry, business, or establishment in which employed (or employer) 041

9-BIRTHPLACE (State or country) Md., U. S. A.

10-NAME OF FATHER Chas W. Bartlett

11-BIRTHPLACE OF FATHER (State or country) Md., U. S. A.

12-MAIDEN NAME OF MOTHER Margaret Penn

13-BIRTHPLACE OF MOTHER (State or country) Md., U. S. A.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Emma A. Gareis

(Address) 2770 Fenwick Ave

15

Robert P. Harrison,

191 Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 12, 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1922, to Feb 12, 1922, that I saw him alive on Feb 11, 1922, and that death occurred, on the date stated above, at 11:40 A. M. The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

Indefinite (Duration) yrs. mos. ds.

Contributory (SECONDARY) Hiccough

(Signed) E. A. Schenk M. D.

Feb 12, 1922 (Address) 1107 N. Caroline St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL London Park

DATE OF BURIAL Feb 15, 1922

20-UNDERTAKER John F. Denny

ADDRESS 715 Light St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61284 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61284

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Fairfield. St. 10 Ward)

Registered No. C. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William E. Neeper.

(Residence in Baltimore: No. 1217 Greenmount Ave. St.; yrs. 3 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, Single (Write the word.)

6-DATE OF BIRTH, December 7th, 1900. (Month) (Day) (Year)

7-AGE, 21 yrs. 2 mos. 5 ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Electric line- (b) General nature of industry, business, or establishment in which employed (or employer), C. G. & E. Co. man.

9-BIRTHPLACE, (State or Country), Harford Co. Md.

10-NAME OF FATHER, William M. Neeper.

11-BIRTHPLACE OF FATHER, (State or Country), Pennsylvania.

12-MAIDEN NAME OF MOTHER, Sadie A. Street.

13-BIRTHPLACE OF MOTHER, (State or Country), Harford Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William M. Neeper. (father)

(Address) Rocks, Harford Co. Md.

15- Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 12th, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to his death (Inquest, autopsy or Inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

Accidentally Electrocuted.  
Came in contact with live wire on  
electric pole.

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(Signature) Wm. M. Penhard M. D.

(Coroner.)

Feb. 12, 1922 (Address) 1217 S. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Rocks, Harford Co. Md. Feb 14, 1922

20-UNDERTAKER, John F. Denny ADDRESS 715 Light St



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61285

## CERTIFICATE OF DEATH.

38 D 61285

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1129 Divinia ST., 17 WARD)

## 2-FULL NAME

Harry Davis

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1129 Divinia ST.,

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

1/10/21

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

22

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

## 10 NAME OF FATHER

Harry Davis

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Towson

## 12 MAIDEN NAME OF MOTHER

Esther Thomas

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

## 14

Informant (Address)

Esther Davis  
1129 Divinia St.

## 15

FEB 14 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

4/12/22

## 17

I HEREBY CERTIFY, That I attended deceased from

4/8, 1922, to 4/12, 1922.

that I last saw him alive on

4/8/22and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH\* was as follows:

Malnutrition

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Examination

(Signed)

R. L. Ellis, M. D.

, 19

(Address)

924 Madison

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

David EasonFeb 14 1922  
9/16  
P.O. Box

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 61286

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

112 D 61286

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 933 Leadenhall ST. 73 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Samuel Sampson

## (a) RESIDENCE. NO.

933 Leadenhall ST.

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofMarcella Sampson6 DATE OF BIRTH (month, day, and year) 1849

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.63

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Latimer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Md  
Cambridge Md

10 NAME OF FATHER

Joseph Sampson11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Md

12 MAIDEN NAME OF MOTHER

unknown13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)unknown

## 14

Informant  
(Address)Frank Sampson Jr  
933 Leadenhall St

## 15

**FEB 14 1922**

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1922

17

HEREBY CERTIFY, That I attended deceased from

Dec 11, 1921, to Feb 11, 1922.that I last saw him alive on Feb 10, 1922.and that death occurred, on the date stated above, at 730 p.m.

The CAUSE OF DEATH\* as follows:

Chronic Gastritis  
Suppurative form  
Eating(duration) yrs. 2 mos. ds.CONTRIBUTORY  
(Secondary)As Thrombosis  
(duration) yrs. 2 mos. ds.18 Where was disease contracted  
if not at place of death?HomeDid an operation precede death? NO Date ofWas there an autopsy? NO

What test confirmed diagnosis?

Obituary L.  
Symptoms(Signed) C. H. Brown, M. D., 19 (Address) 2125 Park St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn Ct Feb 14 1922

20 UNDERTAKER

ADDRESS

J. L. Brown & Son 1121 N. York St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 61287

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61287

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 n. Glen St. ST.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helene Schulz(Residence in Baltimore: No. Life 510 n. Glen St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR-DIVORCED,

(Write the word.)

Widow

6-DATE OF BIRTH,

July 31, 1857  
(Month) (Day) (Year)

7-AGE,

64 yrs. 6 mos. 11 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE, (State or Country).

Balt. Md.

10-NAME OF FATHER,

Henry Pelgrim

11-BIRTHPLACE OF FATHER

(State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Eliz Ulrich

13-BIRTHPLACE OF MOTHER

(State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Carl Schulz  
510 n. Glen St.  
(Address)

15-

ROBERT N. KRAUTER,

Baltimore Health Department Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Feb 11, 1922  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan 9, 1920, to Feb 11, 1922,  
that I saw her alive on Feb 11, 1922,and that death occurred, on the date stated above, at 9:05 P.M.

The CAUSE OF DEATH\* was as follows:

Cerebral HemorrhageCONTRIBUTORY (Secondary) Chronic Arteriosclerosis of Arteries(Signed) Dr. Louis Vogel M.D.  
Feb 12, 1922 (Address) 1102 E. Mount

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Lincoln Park Cemetery Feb. 18, 1922

20-UNDERTAKER

ADDRESS

Louis Hermann 32 S. Broad  
ny

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

61288

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *6* St., *6* Ward)

2-FULL NAME

(Residence in Baltimore: No. *4056* St.; yrs., *1* mos., *22* ds.)

Registered No. C. *61288*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-Single, *Single* Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, *Dec 21* 1890, 1 (Month) (Day) (Year)

7-AGE, *31* yrs., *1* mos., *22* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Salesman* (b) General nature of industry, business, or establishment in which employed (or employer), *Kohn's Sack Co.*

9-BIRTHPLACE, (State or Country), *Baltimore*

10-NAME OF FATHER, *John F. Walch*

11-BIRTHPLACE OF FATHER, (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER, *Bertha Traubner*

13-BIRTHPLACE OF MOTHER, (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John C. Walch*

(Address) *140 S. Streetpersh*

15-

Filed *FEB 14 1922* ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb 12* 1922, (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Multiple Fractures*  
*acute*  
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Fracture*

(Signed) *J. C. Walch* M. D.

(Address) *140 S. Streetpersh*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Immanuel's Con* DATE OF BURIAL, *Feb 15* 1922

20-UNDERTAKER, *Louis Sheeman* ADDRESS, *32 S. Broad*



# D 61289 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

City of BALTIMORE: (No. *Franklin Square No. 27* Ward)

Registered No. C.....

### 2-FULL NAME

*Katherine Labeling*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *4708 Ready* St.; yrs.,..... mos.,..... ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *white* 5-Single, Married, Widowed, or Divorced, *Married* (Write the word.)

6-DATE OF BIRTH, *Sept 21*, 19*04* (Month) (Day) (Year)

7-AGE, *47* yrs. *4* mos. *22* ds. If LESS than 1 day, .... hrs. or .... mo. 7

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *House work* (b) General nature of industry, business, or establishment in which employed (or employer), *at home*

9-BIRTHPLACE, (State or Country), *Balt. Md.*

10-NAME OF FATHER, *Burchal*

11-BIRTHPLACE OF FATHER, (State or Country), *unknown*

12-MAIDEN NAME OF MOTHER, *unknown*

13-BIRTHPLACE OF MOTHER, (State or Country), *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Joseph P. Labeling*

(Address) *4708 Ready*

15- *ROBERT H. KRAUTER,*

*Feb 14 1922* Burial Permit Clerk

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb 13*, 19*22* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH\* was as follows:

*apoplexy*

CONTRIBUTORY (Secondary) *Chronic, Sublethal*

(Signed) *James M. Keaton* M. D. (Coroner.)

*Feb 14 1922* (Address) *705 E. Chase*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents) At place *15* yrs. *8* mos. *2* ds. In the State, yrs.,..... mos.,..... ds.

Where was disease contracted, if not at place of death? *Indeterminate street car*

Former or usual residence *4708 Ready*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*Baltimore Cemetery Feb 16*, 19*22*

20-UNDERTAKER, ADDRESS

*Henry Brock & Son 1301 E. Eager*

N. B.—Every item of information should be carefully stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61290 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

1608 Lamont ave

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No

1608 Lamont ave

ST.:

WARD)

2-FULL NAME

Ida Barnes

(a) RESIDENCE. NO.

1608 Lamont ave

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

16 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Frank A. Barnes

6 DATE OF BIRTH (month, day, and year)

1886 - Mar 7

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

35

11

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Richmond Co  
Va

10 NAME OF FATHER

John Deenoway

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Richmond  
Co Va

12 MAIDEN NAME OF MOTHER

Virginia Surname  
unknown13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Richmond Co Va

14

Informant  
(Address)Husband Frank A. Barnes  
1608 Lamont ave

15

FEB 14 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 1, 1920, to Feb 12, 1922.

that I last saw her alive on Feb 12, 1922.

and that death occurred, on the date stated above, at 9:20 p. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 7 mos. 12 ds.

CONTRIBUTORY  
(Secondary)

Pulmonary Tuberculosis

(duration) 1 yrs. 7 mos. 12 ds.

18 Where was disease contracted

If not at place of death?

Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Sputum ex. 12

(Signed)

C. W. Madson, M. D.

1922

(Address) 1540 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Richmond Co. Virginia

Feb 14 1922

20 UNDERTAKER

ADDRESS

George J. Ruth 1735 Hayford  
Ave.

Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61291

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE, (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No.

St. Life mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE.

White

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Widowed

## 6-DATE OF BIRTH.

July 28, 1857  
(Month) (Day) (Year)

## 7-AGE.

64 yrs. 6 mos. 15 da.

If LESS than 1 day,  
...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Machinist

031

## 9-BIRTHPLACE, (State or Country).

Balto. Md.

## 10-NAME OF FATHER.

Lawrence Smith

## 11-BIRTHPLACE OF FATHER (State or Country).

Ireland

## 12-MAIDEN NAME OF MOTHER

Catherine Keenehan

## 13-BIRTHPLACE OF MOTHER (State or Country).

Ireland

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George J. Smith Jr.

(Address) 607 Denison St.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

Feb 12, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Aug 4, 1921, to Feb 12, 1922.

that I saw him alive on Feb 12, 1922.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH\* was as follows:

Senile Arterio Sclerosis  
Chronic Myocarditis  
(Duration) 4 yrs. 6 mos. 1 da.

## CONTRIBUTORY (Secondary)

(Duration) 1 yr. 6 mos. 1 da.

(Signed) Henry C. Olsen M. D.

Feb 12, 1922 (Address) 1203 W. Fayette St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

New Cathedral

## DATE OF BURIAL.

Feb 15, 1922

## 20-UNDERTAKER

George J. Smith

## ADDRESS

1000 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FEB 14 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61292

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. Veterans Hospital #56

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Ft. McHenry, Baltimore, Md., ST., WARD)

2-FULL NAME James Davis

(a) RESIDENCE No. Ft. McHenry, Baltimore, Md., ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 32 - -

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va. (State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant E.T. Rosenbrock (Address) Registrar

15 FEB 14 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11, 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1922, to Feb. 11, 1922, that I last saw him alive on Feb. 11, 1922, and that death occurred, on the date stated above, at 11.45 P.m. The CAUSE OF DEATH\* was as follows:

Intestinal obstruction acute

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 2/11/22

Was there an autopsy? No

What test confirmed diagnosis? Exploratory Laparotomy

(Signed) J. D. Lusk Surgeon (R) M. D. 19 (Address) Ft. McHenry, Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-NOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.



**D 61293 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61293**

**CERTIFICATE OF DEATH.**

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

**1-PLACE OF DEATH**

CITY OF BALTIMORE: (No. *74-001*)

**2-FULL NAME**

(a) RESIDENCE. NO. *78th*

(Usual place of abode)  
Length of residence in city or town where death occurred yrs. *11* mos. *0*

ST. *78th* WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Female White Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Not Known*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*abt 63 0 0*

**8 OCCUPATION OF DECEASED**

(a) Trade, profession or particular kind of work

*Messenger—formerly*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Not work—*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*(?) Maryland*

10 NAME OF FATHER

*Peter Murphy*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ireland*

12 MAIDEN NAME OF MOTHER

*Margaret Drignan*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ireland*

14 Informant

(Address)

*Records of Mt Hope Retreat  
Mt Hope Balto Md*

15

**FEB 14 1922**

**ROBERT R. KRAUTER,**

Registrar  
Burial Permit Clerk.

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH (month, day, and year) *Feb 13th* 19 *22*

17 I HEREBY CERTIFY, That I attended deceased from *May 19th* 19 *21*, to *Feb 13th* 19 *22*, that I last saw him alive on *Feb 13th* 19 *22*, and that death occurred, on the date stated above, at *11.10 A. m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Paralysis—(Post Cerebral Hemorrhage abt 11 mos ago)*

(duration) 0 yrs. 11 mos. 0 ds.

CONTRIBUTORY

(Secondary)

*Chronic mania*

(duration) 0 yrs. 11 mos. 0 ds.

18 Where was disease contracted

*Baltimore Md*

If not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Frank J. Flannery* M. D.

*Feb 13, 1922* Address *Mt Hope Retreat*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Cathedral Cemetery*

*Feb 15th* 19 *22*

20 UNDERTAKER

ADDRESS

*John P. Cowan 501 Holliston St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61294

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *808 N. Santiago* ST.; *18* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *808 N. Santiago* St.; *8* yrs., *8* mos., *25* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *Col.* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH, *July 6, 1903*  
(Month) (Day) (Year)

7-AGE, *18 yrs. 6 mos. 25 ds.*  
If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *In school*  
(b) General nature of industry, business, or establishment in which employed (or employer) *000*

9-BIRTHPLACE, (State or Country), *Ind.*

## PARENTS.

10-NAME OF FATHER, *William Jones*

11-BIRTHPLACE OF FATHER (State or Country), *Ind.*

12-MAIDEN NAME OF MOTHER *Bessie Thomas*

13-BIRTHPLACE OF MOTHER (State or Country), *Van*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William Jones*(Address) *808 N. Santiago St.*

15-

*FEB 14 1922* ROBERT R. KRAUTER,  
Filed *1922* Burial Permit *0101*

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb. 12, 1922*  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *Sept 25 1921* to *Feb. 12 1922*,  
that I saw her alive on *Feb. 11 1922*,  
and that death occurred, on the date stated above, at *2:4* m.

The CAUSE OF DEATH\* was as follows:  
*Pulmonary Tuberculosis*

(Duration) *8 mos. 25 ds.*  
CONTRIBUTORY *Acute nephritis*  
(Secondary)

(Duration) *1 mos. 1 ds.*  
(Signed) *J. M. Hayes* M. D.  
*Feb. 12, 1922* (Address) *513 N. Washington*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *8 yrs. 8 mos. 25 ds.* In the State *8 yrs. 8 mos. 25 ds.*

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Christopher's* DATE OF BURIAL, *Feb. 14, 1922*

20-UNDERTAKER *Brown, Ireland & Schroeder* ADDRESS *114 N. ...*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61295

D 61295

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 223 W Saratoga ST. WARD)

2-FULL NAME Eva Carter

(a) RESIDENCE. No. 223 W Saratoga ST. WARD.

(Usual place of abode) Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female White Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 17, 1832

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

File

FEB 14 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1922

17 I HEREBY CERTIFY That I attended deceased from

at various times for past several years to Feb 12, 1922.

that I last saw her alive on Feb 6, 1922.

and that death occurred, on the date stated above, at a. m.

The CAUSE OF DEATH\* was as follows:

Valvular heart disease

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Not known

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

None

(Signed) W. A. General M. D.

213, 1922 address 117 W Saratoga St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Int 3 from Harbor

Feb 14 1922

20 UNDERTAKER

ADDRESS

James B. Lee

1414 N. E. Ave

N. WHITE PLAINLY, WITH CAUTION, be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.

D 61296

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 N. Patterson Pk Ave. ST. 8 WARD)

## 2-FULL NAME John W. Reed

(a) RESIDENCE. NO. 1514 N. Patterson Pk Ave. ST. 8 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Etta M. Reed

6 DATE OF BIRTH (month, day, and year)

April 13-1862

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

59

9

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Matthews Co. V.G.

10 NAME OF FATHER

John W. Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Matthews Co. V.G.

12 MAIDEN NAME OF MOTHER

May C. Townsend

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Ind

14

Informant (Address)

Mrs. J. Wm. Rossil 1514 N. Patterson Pk Ave.

15

Filed

FEB 14 1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 11, 1922

17

I HEREBY CERTIFY, That I attended deceased from July 10, 1921, to February 11, 1922, that I last saw him alive on February 9, 1922, and that death occurred, on the date stated above, at 10:30 P. M.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary)

Arterial Sclerosis (duration) yrs. mos. ds. 7 mon. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests (Signed) Albert S. Singer M. D.

2/10/1922 (Address) 1613 E. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Balto. Genl. Burial

20 UNDERTAKER

J. J. New 156 N. Luzerne Ave.



D 61297

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61297

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No

330 S Central Ave ST.

WARD) 3

## 2-FULL NAME

James Foreston

## (a) RESIDENCE, No

330 S Central Ave ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

## 6 DATE OF BIRTH (month, day, and year)

Unknown

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

38

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Tennessee live in Balt - ops

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

## 14

Informant (Address)

Mary Jones 330 S Central Ave

## 15

Filed

19

FEB 14 1922

BUREAU PERMIT CLERK

Registrar

Burial Permit Clerk

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb 12 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan. 19th, 1922, to Feb. 12, 1922

that I last saw him alive on Feb. 12, 1922

and that death occurred, on the date stated above, at 5:25 A. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Same

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) Jacob L. Wimmer, M. D.

273, 1922 (Address) 30 S. B'way

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Int-Aurum Cen

Feb 14 1922

## 20 UNDERTAKER

Mrs Robert A Elliott

ADDRESS 1725 Ashland

D 61298

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61298

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 429 Colvin ST.: 5 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. 429 Colvin ST.: \_\_\_\_\_ WARD. \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.How long in U. S., if of foreign birth? 60 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

James H. Jackson

6 DATE OF BIRTH (month, day, and year)

1841

7 AGE

Years

Months

Days

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

19

ROBERT R. KRAUTER, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 12 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 1 1922 to Feb 12 1922that I last saw him alive on Feb 10th 1922and that death occurred, on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH\* was as follows:

Diabetic Gangrene  
Right foot

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
If not at place of death?Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? Urinalysis

(Signed)

Harriet M. Jones, M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Laural Cemetery

DATE OF BURIAL

Feb 16 1922

20 UNDERTAKER

Mrs Robert A ElliottADDRESS 1725Ashland

FEB 14 1922

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61299

## CERTIFICATE OF DEATH.

91-001 D 61299

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Little Sister of Mrs. Parr* ST. *10* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Hermann Wolf*(a) RESIDENCE. NO. *Fresno Valley St.* ST. *10* WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S., if of foreign birth? *50* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widower*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *J. Annie*6 DATE OF BIRTH (month, day, and year) *13 Nov. 1848*7 AGE Years *73* Months *10* Days *=* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *R. R. Clerk*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Germany* (State or country)10 NAME OF FATHER *George Wolf*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *Annie Schnatz*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant *Little Sister of Mrs. Parr* (Address) *Parr*15 Filed *ROBERT R. KRAUTER* Registrar

Burlal Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 13 1922*17 I HEREBY CERTIFY, That I attended deceased from *12 noon* to *1922*that I last saw him alive on *July 12*, 1922.and that death occurred, on the date stated above, at *11.30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Gangrene of foot**1 week* (duration) yrs. mos. ds.CONTRIBUTORY *Arterio sclerosis* (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed) *F. U. Warner*, M. D.1922 (Address) *1133 Valley St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*New Cathedral Cem.* *Feb 15*20 UNDERTAKER ADDRESS *1200**John J. Fields* *H. Amberg*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 14 1922

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Senile gangrene.*



N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT-CITY OF BALTIMORE

D 61300

## CERTIFICATE OF DEATH

REGISTERED No. C

D 61300

### PLACE OF DEATH

CITY OF BALTIMORE (No. 1109 Bolton)

ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nannie E. Reinhardt

(Residence in Baltimore: No. 1109 Bolton)

St. 27 yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH April 24, 1865  
(Month) (Day) (Year)

7 AGE 56 yrs. 9 mos. 19 ds. or min.?  
If LESS than 1 day, hrs.

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed (or employer) 837

9 BIRTHPLACE (State or country) Richmond, Va

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George J. Reinhardt

(Address) 1109 Bolton

15.

FEB 14 1922 ROBERT R. KRAUTER  
REGISTRAR

Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 12, 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from Feb 10, 1922 to Feb 12, 1922.

that I saw her alive on Feb 12, 1922

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH\* was as follows:  
Mitral Regurgitation

(Duration) yrs. mos. ds

Contributory Acute Endocarditis  
(SECONDARY)

(Duration) yrs. mos. ds. 2

(Signed) Henry E. Gale M. D.  
Feb 12, 1922 (Address) 260 W. Hoffman

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL London Park DATE OF BURIAL Feb 14, 1922

20 UNDERTAKER E. W. Dill ADDRESS 8109 Fredk. Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61301 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61301

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 434 E. Fort Ave. St. 24 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

George H. Brewer.

53 -- 1 --- 6.

(Residence in Baltimore: No. 434 E. Fort Ave. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

6-DATE OF BIRTH, January 6th, 1869, 1. (Month) (Day) (Year)

7-AGE, 53 yrs. 1 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Watchman. (b) General nature of industry, business, or establishment in which employed (or employer), U. S. Ind. Chem. Co.

9-BIRTHPLACE, (State or Country), Baltimore Md.

10-NAME OF FATHER, J. J. Baran. Do not know.

11-BIRTHPLACE OF FATHER, Md. Do not know.

12-MAIDEN NAME OF MOTHER, Elizabeth Anny. Do not know.

13-BIRTHPLACE OF MOTHER, Ala. Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry S. Brewer (Son).

(Address) 1507 Abbottston St.

15-

ROBERT R. KRAUTER, Registrar. FEB 14 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 12th, 1922, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cerebral Apoplexy.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. H. Reinhardt, M. D. (Coroner.)

Feb. 13, 1922. (Address) 10 N. E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Corday Hill Cemetery 2/14/1922

20-UNDERTAKER,

ADDRESS

E. H. Reinhardt 1400 Rutledge St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 61302

D 61302

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 536 N. Gilman ST.; 19 WARD)2-FULL NAME Leonard A. Bowen(Residence in Baltimore: No. 536 N. Gilman St. St.; ..... yrs., ..... mos., ..... da.)100-111  
REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX m.4-COLOR OR RACE, col5-SINGLE, Single  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)6-DATE OF BIRTH, June 20, 1921

(Month)

(Day)

(Year)

7-AGE, 6 yrs. 12 mos. 12 da.

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work Infant(b) General nature of industry, business, or establishment in which employed (or employer) aux.9-BIRTHPLACE, Balto Md.

(State or Country)

10-NAME OF FATHER, Arthur Bowen

11-BIRTHPLACE OF FATHER

(State or Country), Md.12-MAIDEN NAME OF MOTHER Elizabeth Bowen

13-BIRTHPLACE OF MOTHER

(State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elizabeth Bowen(Address) 536 N. Gilman St.

15-

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 12, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1922, to Feb. 12, 1922,that I saw him alive on Feb. 12, 1922,and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia

(Duration)..... yrs..... mos..... da.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... da.

(Signed) Jon Hayer M. D.713, 1922 (Address) 513 N. Gilman St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... da. In the State..... yrs..... mos..... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Laurel CemeteryFebruary 14, 1922

20-UNDERTAKER

ADDRESS

Mrs. Katie R. Williams1114 W. Lutz St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION if any important. See instructions on back of certificate.

*No infection prior*

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

*lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

<i>Abortion,</i>	<i>Cellulitis,</i>	<i>Childbirth,</i>	<i>Convulsions,</i>
<i>Hæmorrhage,</i>	<i>Gastritis,</i>	<i>Erysipelas,</i>	<i>Meningitis,</i>
<i>Gangrene,</i>	<i>Miscarriage,</i>	<i>Necrosis,</i>	<i>Peritonitis,</i>
<i>Phlebitis,</i>	<i>Pyæmia,</i>	<i>Septicæmia,</i>	<i>Tetanus.</i>

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (if induced), whether death is directly or indirectly due to the same.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61303

## CERTIFICATE OF DEATH.

129 D 61303

1-PLACE OF DEATH *Church Home and Infirmary*

REGISTERED NO.

CITY OF BALTIMORE: (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

*Mrs. Rosa Moorman*

(a) RESIDENCE NO.

*658 Bartlett Ave.*

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

*5* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**White**Married*

5a If married, widowed, or divorced

(or) WIFE of

*Abraham L. Moorman*

6 DATE OF BIRTH (month, day, and year)

*Nov. 28-1876*

7 AGE

Years

Months

Days

If LESS than 1 day, ... hrs or ... min.

*45**2**15*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*House wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Illinois*

10 NAME OF FATHER

*unknown*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*unknown*

12 MAIDEN NAME OF MOTHER

*unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*unknown*

14

Informant (Address)

*Abraham L. Moorman  
658 Bartlett Ave*

15

ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 12* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from *Feb. 7*, 19 *22*, to *Feb 11*, 19 *22*,that I last saw him alive on *Feb 12*, 19 *22*,and that death occurred, on the date stated above, at *10:05 A.M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Nephritis  
myocarditis*(duration) *2* yrs. *0* mos. *0* ds.

CONTRIBUTORY (Secondary)

(duration) *0* yrs. *0* mos. *0* ds.

18 Where was disease contracted ( ) If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *Autopsy*(Signed) *Kayetan Panethiers* M. D., 19 (Address) *Church Home and Infirmary*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Funeral Home**Feb. 15* 19 *22*

20 UNDERTAKER

ADDRESS

*H. E. Hughes* *121 N. Broadway*

mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 14 1922

D 61304

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61304

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1015 Homewood Ave. 10

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Annie Loughran

## (a) RESIDENCE

No. 1015 Homewood Ave.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female White

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced (write the word)

Widow

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Patrick Loughran

## 6 DATE OF BIRTH (month, day, and year)

June 22-1844

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Ireland

## 10 NAME OF FATHER

Michael Gilchrist

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

## 12 MAIDEN NAME OF MOTHER

Annie McGeer

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

## 14

Informant (Address)

Annie J. Loughran 1015 Homewood Ave.

## 15

Filed

626141922

ROBERT R. KRAUTER

Burial Permit Clerk

## 20 UNDERTAKER

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cathedral

## DATE OF BURIAL

Feb 15, 1922

## ADDRESS

J. C. Wiedefeld 914 Summit St.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

2-11-22

## 17

HEREBY CERTIFY, That I attended deceased from

1/7, 1922, to 2/11, 1922,

that I last saw him alive on 2/10, 1922.

and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH\* was as follows:

Chr. Endocarditis

(duration) Unknown

## CONTRIBUTORY (Secondary)

Disease of lungs

(duration) yrs. 1 mos. ds.

## 18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

## What test confirmed diagnosis?

(Signed) Dr. Bernard Weiss, M. D.

, 19 (Address) 914 E. Reddell

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

N. B.—Every item of information should be carefully supplied. AGE should be stated in years. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE 61305

D 61305

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1218 Greenmount 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1218 Greenmount)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE white 5-SINGLE, MARRIED, WIDOW, OR DIVORCED (Write the word.)

6-DATE OF BIRTH, June 26, 1855 (Month) (Day) (Year)

7-AGE, 66 yrs. 7 mos. 16 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Boiler maker (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). New York

10-NAME OF FATHER, James Hume

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER, Ann McIlver

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Annie M. Hume

(Address) 1213 Greenmount Ave.

15-

Filed FEB 14 1922 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 12, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Apoplexy (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. H. Hume M. D.

(Coroner) 2-13, 1922 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral DATE OF BURIAL, Feb. 15, 1922

20-UNDERTAKER, J. C. Wiedefeld ADDRESS, 914 Greenmount Ave.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61306 HEALTH DEPARTMENT—CITY OF BALTIMORE 185 D 61306

CERTIFICATE OF DEATH.

1-PLACE OF DEATH S/S Wabash. W.Md.R.R.Co.

Registered No. C.....

City of BALTIMORE: (No. .... Port Covington, .... St. .... Ward) 1

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ..... John Stocki.

(Residence in Baltimore: No. .... 3034 Boston St. .... St.; yrs. .... 20 .... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, 4-COLOR OR RACE, 5-Single, Married, Widowed, or Divorced, (Write the word.)  
Male. White. Married.

6-DATE OF BIRTH, (Month) (Day) (Year)  
Do not know. .... 1

7-AGE, If LESS than 1 day, .... hrs. or .... min.?  
43 yrs. .... mos. .... ds.

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, Stevedore.  
(b) General nature of industry, business, or establishment in which employed (or employer) 074

9-BIRTHPLACE, (State or Country), Poland.

10-NAME OF FATHER, Peter Stocki.

11-BIRTHPLACE OF FATHER, (State or Country), Poland.

12-MAIDEN NAME OF MOTHER, Mary

13-BIRTHPLACE OF MOTHER, (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Stocki. (wife)

(Address) 3034 Boston St.

15- FEB 14 1922 ROBERT R. KRAUTER, Filed

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 11th, 1922, 1922.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Fracture of the skull.  
Accidental fall into the hold of  
S/S Wabash.  
(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) (Duration) .... yrs. .... mos. .... ds.  
(Signed) Otto M. Penhard M. D. (Coroner)  
Feb. 13, 1922. (Address) 1015 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).  
At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.  
Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Holy Rosary Cemetery Feb. 15, 1922.

20-UNDERTAKER, ADDRESS

M. J. Sadowski 705 S. Ann St.



Every item on this form is a statement of fact. It must be filled in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificate.

D 61307 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61307

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *188-007*)

2-FULL NAME

(Residence in Baltimore: No. *245 S. Castle*)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OF RACE

5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison

16-

Burial Permit Clerk

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an..... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....

and that said deceased came to death.....

on the day stated above.

THE CAUSE OF DEATH\* was as follows:

Multiple Fractures  
Auto accident

CONTRIBUTORY (Secondary)

(Signed)

(Coroner)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 61308

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1833 N. Baltimore ST.: 18 WARD)

2-FULL NAME Grace E. H. Hallett

(a) RESIDENCE. No. 1833 N. Baltimore

(Usual place of abode)

Length of residence in city or town where death occurred

ST., WARD.

(If nonresident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 6 1867

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

54 11 1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Robert F. Harrison,

Registrar

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1922

17 I HEREBY CERTIFY, That attended, deceased from

Feb 12 1922, to Feb 12 1922

that I last saw her alive on Feb 12 1922

and that death occurred, on the date stated above, at 10:20 p.m.

The CAUSE OF DEATH\* was as follows:

Diabetes Mellitus

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Information should be carefully supplied. See instructions on back of certificates.

B141922

Burial Permit Clerk.

D 61309 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 234 S. Collington Ave. ST.)

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 234 S. Collington Ave. ST.; Life yrs., mos., ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

## 6-DATE OF BIRTH.

Dec. 8, 1842  
(Month) (Day) (Year)

## 7-AGE,

79 yrs. 2 mos. 4 ds.

If LESS than 1 day, ...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House work.

## 9-BIRTHPLACE, (State or Country),

Balto. Md.

## 10-NAME OF FATHER,

Richard M. Albese

## 11-BIRTHPLACE OF FATHER

(State or Country),

Ireland

## 12-MAIDEN NAME OF MOTHER

Martha Brown

## 13-BIRTHPLACE OF MOTHER

(State or Country),

Balto. Md.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Connolly

(Address) 234 S. Collington Ave.

## 15-

Robert F. Harrison,

191

Registrar.

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Feb. 12, 1922  
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

Feb 3 1922, to Feb 12 1922

that I saw h. alive on Feb 12 1922,

and that death occurred, on the date stated above, at 2<sup>45</sup> p.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Leo Heller M. D.

2113 22 (Address) 1937 Gough St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

St. Patrick's Cemetery

## DATE OF BURIAL,

Feb 18, 1922

## 20-UNDERTAKER

## ADDRESS

John A. Moran 3000 E. Balto St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61310

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 18 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Todd(a) RESIDENCE. NO. 404 Fremont Ave ST. 18 WARD. 18  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18597 AGE Years Months Days If LESS than 1 day, hrs. or min.  
62 -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cambridge, Md.  
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown  
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)14 Informant Hospital Records,  
(Address) Municipal Hospital.15 Filed Robert F. Harrison Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10 192217 I HEREBY CERTIFY, That I attended deceased from  
February 8, 1922, to February 10, 1922that I last saw him alive on February 10, 1922and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis(duration) 1 yrs. mos. ds.CONTRIBUTORY  
(Secondary)(duration) 1 yrs. mos. ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. M. D.2/14/22 Address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

JOHNS HOPKINS HOSPITAL FEB 14 1922

20 UNDERTAKER

ADDRESS

Exact statement of Occupancy  
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

FEB 14 1922

Burial Permit Clerk



## HEALTH DEPARTMENT—CITY OF BALTIMORE

61311

D 61311

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 6 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Jansen(a) RESIDENCE. NO. 1928 E. Fayette St. ST. 6 WARD. 6  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofUnknown6 DATE OF BIRTH (month, day, and year) 1870 May 7 18707 AGE Years Months Days If LESS than 1 day, hrs. or min.  
51 -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,  
(State or country) Maryland10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown  
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)14 Informant Hospital Records,  
(Address) Municipal Hospital.15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13 192217 I HEREBY CERTIFY, That I attended deceased from  
November 19, 1919, to February 13, 1922.that I last saw her alive on February 12, 1922.and that death occurred, on the date stated above, at 5:45 A.M.

The CAUSE OF DEATH\* was as follows:

Multiple Sclerosis(duration) 5 yrs. mos. ds.CONTRIBUTORY  
(Secondary)(duration) 3 yrs. mos. ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis?  
(Signed) Clyde McNeill M. D.2/13/22 Address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Western Cemetery Feb 15 1922

20 UNDERTAKER ADDRESS

A. S. Hippest 2216 Freshwater

Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

174 1922

## D 61312

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

St.; 40 yrs., ..... mos. .... ds.

**MEDICAL CERTIFICATE OF DEATH.**

3-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

.....  
 (Month) (Day) (Year)

51 yrs. 10 mos. 25 ds

....hrs. or....min.

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

**10-NAME OF FATHER,**

**11-BIRTHPLACE  
OF FATHER  
(State or Country).**

**12-MAIDEN NAME  
OF MOTHER**

**13-BIRTHPLACE  
OF MOTHER  
(State or Country).**

(Informant).....*W. H. Green, Jr.*.....

(Address) 901 Red 1/2

Filed..... 191.....

.....*Feb*.....*13*....., 19*28*.....  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from  
February 10, 1922, to February 12, 1922.

that I saw h...e... alive on April 12, 1922,  
and that death occurred, on the date stated above, at ..... m.

**The CAUSE OF DEATH\* was as follows:**

Myocarditis Acute  
(Duration)..... yrs. 1. mos. 4

CONTRIBUTORY..... *Joseph Carline*  
(Secondary)

..... (Duration) ..... yrs. 2 mos. .... d.

(Signed).....*[Signature]*.....

13. February 1922 (Address) 782 S. Ann. St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted,  
if not at place of death? .....

**Former or usual residence** .....

**19-PLACE OF BURIAL OR REMOVAL.**

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

EB 141922 Serial Permit 61075 Registrar.

# D 61313 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61313

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

City of BALTIMORE: (No. 1726 S. Charles St. St. 23 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....William Thomas.....

(Residence in Baltimore: No. 1726 S. Charles St. St.; yrs. .... mos. .... ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH, February 13th, 1922. 1. .... (Month) (Day) (Year)

7-AGE, If LESS than 1 day, 11 hrs. or .... min. ?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore Md.

10-NAME OF FATHER, Michael J. Thomas.

11-BIRTHPLACE OF FATHER, (State or Country), Cumberland Md.

12-MAIDEN NAME OF MOTHER, Annie C. Erey.

13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie C. Thomas. (mother).

(Address) 1726 S. Charles St.

15- Robert P. Harrison, Registrar.

Filed 1922

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 13th, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Mitral Insufficiency. (Congenital).

(Duration) yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. .... mos. .... ds.

(Signed) M. D.

(Coroner) 1019 S. Charles St.

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. .... mos. .... ds. In the State, yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20-UNDERTAKER ADDRESS

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1922

Burial Permit No. 1318

D 61314

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61314

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO. *Howard G Kelly Hospital ST. 14* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Lillie B. Farish (Mrs. Lillie)*(a) RESIDENCE. NO. *Rome 705 - Waldorf-Astoria ST., New York City*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *3*mos. *✓*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female white*

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*J. F. Farish*

6 DATE OF BIRTH (month, day, and year)

*Jan 6 1871*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*51**1**8*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*North Carolina*

10 NAME OF FATHER

*J. A. Bittling*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*North Carolina*

12 MAIDEN NAME OF MOTHER

*Louisa Wilson*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*North Carolina*

14

Informant

(Address)

*J. F. Farish**Waldorf Astoria New York City*

15

Filed

19

*Robert P. Harrison,*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb. 14<sup>th</sup> 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*May 17<sup>th</sup> 1921, to Feb. 14<sup>th</sup> 1922*that I last saw her alive on *Feb. 14<sup>th</sup> 1922*and that death occurred, on the date stated above, at *11<sup>20</sup> A. M.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Glands - Right Groin*(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date of *✓*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Gus H. Brownell*, M. D.*2/14, 1922 Address 7418 Eutaw Place*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cremated Linden Park Cemetery Feb 15 1922*

20 UNDERTAKER

ADDRESS

*Chas. G. Black 742 W. North Ave.*

Cause of death in plain terms, so that it may be properly classified. See instructions on back of certificates.

8741922

Burial Permit Clerk.



D 61315

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61315

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *200 York Ave* ST. *15* WARD)

## 2. FULL NAME

*Miss Mary Shannon*

## (a) RESIDENCE NO.

*300 York Ave*  
(Usual place of abode)  
Length of residence in city or town where death occurred *25* yrs. mos. ds.

ST. WARD

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White Married*5a If married, widowed, or divorced  
HUSBAND of  
WIFE of *George Shannon*6 DATE OF BIRTH (month, day, and year) *June 16 1893*

7 AGE

Years Months Days

If LESS than  
1 day, hrs.  
or min.*65 7 26*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*None*

9 BIRTHPLACE (city or town, State or country)

*Harford Co Md*

10 NAME OF FATHER

*Emmanuel May Jr*

11 BIRTHPLACE OF FATHER (city or town, State or country)

*Maryland*

12 MAIDEN NAME OF MOTHER

*Elizabeth Howe*

13 BIRTHPLACE OF MOTHER (city or town, State or country)

*Maryland*

14

Informant (Address)

*My. McNamee  
200 York Ave*

15

Registrar

Burial Permit Clerk?

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 12 1922*17 I HEREBY CERTIFY, That I attended deceased from *Sept 1<sup>st</sup>* 1920, to *Feb. 12* 1922.and that death occurred, on the date stated above, at *7.00 P. m.*

The CAUSE OF DEATH\* was as follows:

*Thrombo-phlebitis, Septicemia**(terminal infection)**(Chronic hepatitis, Chronic heart disease)*(duration) *0* yrs. *0* mos. *3* ds.CONTRIBUTORY (Secondary) *Cardio-renal anasarca*(duration) *2* yrs. *0* mos. *0* ds.18 Where was disease contracted if not at place of death? *no*Did an operation precede death? *no* Date of *no*Was there an autopsy? *no*What test confirmed diagnosis? *fever, pain, phlebitis etc*(Signed) *J. A. Dadds* M. D.19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Rockbridge Ave. Harford Co*20 UNDERTAKER *W. J. Tucker*DATE OF BURIAL *Feb 14 1922*ADDRESS *North Ave*

B141922

Rebert P. HARRIS

Burial Permit Clerk?

Registrar

*W. J. Tucker**North Ave*

Exact statement of Occurrence should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61316

## CERTIFICATE OF DEATH.

D 61316

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *611 S. 15th*ST.: *76* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Les. A. Fisher*(a) RESIDENCE, No. *611 S. 15th*

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*M*

## 4 COLOR OR RACE

*W*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Single*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct 29/1894*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*27**3**14*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Clerk 004*

(b) General nature of industry, business, or establishment in which employed (or employer)

*B-O-R R.*

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Md*

## 10 NAME OF FATHER

*John Fisher*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Poland*

## 12 MAIDEN NAME OF MOTHER

*Anna Wajer*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Poland*

## 14

Informant (Address)

*Anna Eckes 611 S 15th*

## 15

Filed

*Robert P. Harrison,*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 12 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*Dec 18, 1921, to Feb 12, 1922,*that I last saw him alive on *Feb 11, 1922,*and that death occurred, on the date stated above, at *3:25 p. m.*

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis.*(duration) *1* yrs. mos. ds.

## CONTRIBUTORY (Secondary)

*Cardiac Exhaustion*(duration) *2* yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death? *—*Did an operation precede death? *—* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical.*(Signed) *A. L. Huntleson*, M. D.*4/13 1922 Address 2013 B Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Holy Rosary**2/16 1922*

## FUNERAL

## ADDRESS

*774 Halliwell 168 Eastern*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B 141922

Burial Permit Clerk.

Every item of information should be carefully supplied. AGE should be stated. **CAUSE OF DEATH** in plain terms, so that it may be properly classified. **Exact statement of OCCUPATION** is very important. See instructions on back of certificate.





REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Former* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No gall stones.*  
*No further history.*

D 61319

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61319

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No.

ST.:

WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

FEB 15 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

2/11/22 to 2/18/22

that I last saw him alive on 2/13/22

and that death occurred, on the date stated above, at 9:25 a.m.

The CAUSE OF DEATH was as follows:

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

10 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of 2/1/22

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61320

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1313 Belair Rd. ST. 8 WARD)

## 2-FULL NAME

William M. Alexander

## (a) RESIDENCE. NO.

1313 Belair Rd. ST. 8 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? 1 yrs. 1 mos. 1 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of —6 DATE OF BIRTH (month, day, and year) Jan. 5, 19217 AGE Years 1 Months 1 Days 8 If LESS than 1 day, — hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —(b) General nature of industry, business, or establishment in which employed (or employer) —(c) Name of employer —9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)10 NAME OF FATHER James M. Alexander11 BIRTHPLACE OF FATHER (city or town) A. C. (State or country)12 MAIDEN NAME OF MOTHER Blanche M. Talheimer13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)14 Informant James M. Alexander (Address) 1313 Belair Rd.15 Filed FEB 15 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13, 192217 I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1922, to Feb. 13, 1922, that I last saw him alive on Feb. 13, 1922, and that death occurred, on the date stated above, at 5:10 p. m.

The CAUSE OF DEATH\* was as follows:

Broncho-PneumoniaCONTRIBUTORY (Secondary) Severe Cold (duration) yrs. 10 mos. 10 ds.18 Where was disease contracted if not at place of death? Place of deathDid an operation precede death? — Date of —Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Wm. M. Pannbaker M. D.19 (Address) 109 Madison Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Parkwood Cemetery

## 20 UNDERTAKER

George Schilling & Sons

## DATE OF BURIAL

Feb. 15<sup>th</sup> 1922

## ADDRESS

1126 E. Monument St.

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 61321

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61321

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal HospitalST.: 76 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Sowers(a) RESIDENCE. NO. ----

(Usual place of abode)

ST. ---- WARD. ----

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
----------------------	---------------------------------	--

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 2-3-22

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
--	--	--	11	--

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work ---(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,  
(State or country) Maryland10 NAME OF FATHER George Sowers11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country) Maryland12 MAIDEN NAME OF MOTHER Georgia Bennett13 BIRTHPLACE OF MOTHER (city or town) Baltimore,  
(State or country) Maryland14 Informant Hospital Records,(Address) Municipal Hospital.

15 FEB 15 1922 ROBERT R. KRAUTER,

Burial Permit Clerk, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 19 22

17 I HEREBY CERTIFY, That I attended deceased from  
February 4, 1922, to February 14, 1922.  
that I last saw him alive on February 14, 1922.  
and that death occurred, on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH\* was as follows:

Inanition(duration) yrs. mos. 8 ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? --- Date of ---Was there an autopsy? noWhat test confirmed diagnosis? Chlorine study  
(Signed) L. H. Drumbois M. D.2/14/22 address) Municipal Hospital.\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

M. Carmel Beau.2/15/22

20 UNDERTAKER

Harold Eastin 516 Penna Cr.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in very important. See instructions on back of certificate.

D 61322

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1790 61322

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *107 N. Carey* ST. *85* WARD)

2-FULL NAME

(Residence in Baltimore: No. *107 N. Carey* ST. *85*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*Female*

4-COLOR OR RACE,

*white*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *single*

6-DATE OF BIRTH,

*Sept. 1, 1908*  
(Month) (Day) (Year)

7-AGE,

*13 yrs. 5 mos. 13 ds.*

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

*schoolgirl*

9-BIRTHPLACE, (State or Country),

*Baltimore*

10-NAME OF FATHER,

*George W. Rosenberger*

11-BIRTHPLACE OF FATHER (State or Country),

*Md.*

12-MAIDEN NAME OF MOTHER

*Edith May Dorsey*

13-BIRTHPLACE OF MOTHER (State or Country),

*Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FEB 15 1922

ROBERT B. KRAUTER,

831 N. Vester St. Baltimore

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Feb. 14, 1922*  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*3rd Burns on back of head, face, caught by stove*  
*Accident* (Duration) yrs. mos. *1/2* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *James M. Benton* M. D.

*Feb. 14 1922* (Address) *700 E. Chase St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place *Franklin St. 85* In the of death yrs. mos. *1/2* ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death? ....

*107 N. Carey St.*

Former or usual residence *107 N. Carey St.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Lorraine Cemetery*

*Feb. 15, 1922*

20-UNDERTAKER

ADDRESS

*John Mitchell 1201 W. Fayette St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61323

## CERTIFICATE OF DEATH.

129 D 61323

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1054 H. Balto ST.; 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1054 H. Balto St.; 70 yrs., mos., ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. Female 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widowed (Write the word.)

6-DATE OF BIRTH. Feb 4, 1848 (Month) (Day) (Year)

7-AGE. 82 yrs., mos., ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Retired (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Germany

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank A. Henskel

(Address) 1054 H. Balto St.

15-

Filed 191. ROBERT R. KRAUTER, Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 14, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 31 1919, to Feb 14 1922, that I saw her alive on Feb 13 1922, and that death occurred, on the date stated above, at 3:15 p.m.

The CAUSE OF DEATH\* was as follows:

Acute Cardiac Dilatation + Pulmonary Edema

(Duration) 5 yrs., 11 mos., 14 ds. CONTRIBUTORY Chronic Interstitial Nephritis + Chronic Myocarditis (Duration) 2 yrs., 11 mos., 6 ds.

(Signed) Henry C. Coffey, M. D. Feb 14, 1922 (Address) 1203 W. Fayette St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, 7 DATE OF BURIAL, Loudon Park Feb 16, 1922

20-UNDERTAKER ADDRESS John Ountchell 1203 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly entered. Enter statement of occupation in plain terms. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61324

## CERTIFICATE OF DEATH.

31 D 61324

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 542 N Carrollton Ave ST. 18 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. 542 N Carrollton Ave.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 40 mos. 2 ds. 9 How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 4 1873

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

49 2 9

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Supt. Emerson Drug Co.

9 BIRTHPLACE (city or town) (State or country)

Balto, Md

10 NAME OF FATHER

Howard Swain.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Delaware

12 MAIDEN NAME OF MOTHER

Francis Bennett

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

14

Informant (Address)

Mary J. Swain 542 N Carrollton Ave

15

FEB 15 1922

19

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1922

17

HEREBY CERTIFY, That I attended deceased from

Dec. 29, 1921, to Feb 13, 1922

that I last saw him alive on Feb 12, 1922

and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Tubercular Laryngitis

(duration) yrs. 1 1/2 mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw. V. Coakley, M. D.

1922 (Address) 24 N Fulton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Landon Park

Feb. 16 1922

20 UNDERTAKER

ADDRESS

John O. Mitchell, 201 N. Fayette St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT--CITY OF BALTIMORE

D 61325

## CERTIFICATE OF DEATH

11-001

D 61325

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME

Residence in Baltimore: No.

ST.

yrs.

mos.

ds.)

### PERSONAL AND STATISTICAL PARTICULARS

### MEDICAL CERTIFICATE OF DEATH

3 SEX

4 COLOR OR RACE

5 MARRIAGE STATUS

Widow  
(If write the word)

6 DATE OF BIRTH

November 30, 1845  
(Month) (Day) (Year)

7 AGE

76 yrs. 2 mos. 13 ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Retired

9 BIRTHPLACE

(State or country)

Westminister Md.

PARENTS

10 NAME OF FATHER

John W. Jingling Md.

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

Louisa M. Wayfield Md.

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Maude I Brooks  
636 W. North Ave

(Address)

16 DATE OF DEATH

Feb. 13, 1922  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Feb 5, 1922, to Feb 13, 1922

that I saw her alive on Feb 12, 1922

and that death occurred, on the date stated above, at 4:45 a.m.

The CAUSE OF DEATH\* was as follows:

Influenza - (Grippe)

Contributory (SECONDARY)

Broncho-Pneumonia

(Signed)

Carroll Lockard M.D.  
Feb 13, 1922 (Address) 42 Preston St

\*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.  
Where was disease contracted?  
If not at place of death?  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Green Mount

Feb. 15, 1922

20 UNDERTAKER

ADDRESS

John Mitchell

1201 W. Fayette St.

ROBERT N. KRAUTER,

Burial Permit Clerk

15

FEB 15 1922

REGISTRAR



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61326

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a if married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

FEB 15 1922

ROBERT R. KRAUTER  
Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 22

17

I HEREBY CERTIFY, That I attended deceased from

1/31/1922, to 2/14/1922

that I last saw him alive on 2/14/1922

and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia (Lobar)

(duration)

yrs.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 10 Date of

Was there an autopsy? 20

What test confirmed diagnosis?

(Signed)

Julius H. Rosenbaum M. D.

19

(Address) Helms Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Helms Hospital  
Jack Lewis 1439 E. Pratt

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61327

## CERTIFICATE OF DEATH.

D 61327

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

903 S Potomac St.

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Adam J Szalkowski

(a) RESIDENCE. NO.

903 S Potomac St.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

4 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 5 - 22

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

1

22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore Md

10 NAME OF FATHER

Bronslaw Szalkowski

11 BIRTHPLACE OF FATHER (city or town)

Szalkowski

(State or country)

Poland

12 MAIDEN NAME OF MOTHER

May Buzick

13 BIRTHPLACE OF MOTHER (city or town)

Poland

(State or country)

14

Informant

(Address)

Bronslaw Szalkowski  
903 S Potomac St.  
BALTIMORE, MD

15

FEB 15 1922

ROBERT A. KRAMER,  
Burial Permit Clerk,  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 14 - 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 14, 1922, to Feb. 14, 1922.

that I last saw him alive on Feb. 14, 1922.

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:

Bronchitis - Pneumonia

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

Myocardial Insufficiency

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Physical Signs

(Signed)

D. B. Bronkhus M. D.

(Address) 3037 Odorwell St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Adam Szalkowski

Feb. 16, 1922

20 UNDERTAKER

ADDRESS

Stephen Szalkowski

1005 [unclear]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 61328

HEALTH DEPARTMENT—CITY OF BALTIMORE

61328

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

University Hospital

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Edward Thomas Adams

## (a) RESIDENCE. No.

St. George Island, Md.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

12 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Ida Irene Adams

## 6 DATE OF BIRTH (month, day, and year)

Aug 1857

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

64

7

26

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

Commercial

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)St. Marys County  
Maryland

## 10 NAME OF FATHER

Thomas Adams

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Virginia

## 12 MAIDEN NAME OF MOTHER

Ida Chester

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)St. George Island  
St. Marys Co. Md.

## 14

Informant

Miss Flo Adams

(Address)

St. George Island. Md.

## 15

Filed

FEB 15 1922

J. E. Kuhn

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb. 14

1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb. 2 - 1922, to Feb. 14<sup>th</sup>, 1922,that I last saw him alive on Feb. 14<sup>th</sup>, 1922,

and that death occurred, on the date stated above, at 12.36 P. M.

The CAUSE OF DEATH\* was as follows:

Uremia  
Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

Hypertensive prostate

(duration) 5 yrs. mos. ds.

## 18 Where was disease contracted:

If not at place of death?

Did an operation precede death? Yes Date of Feb. 9, 1922

Was there an autopsy? No

## What test confirmed diagnosis?

(Signed) Cyrus J. Hume M. D.

, 19 (Address) University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Piney Point Md.

Feb 15 1922

## 20 UNDERTAKER

Wm Routern

## ADDRESS

230 N. Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61329

## CERTIFICATE OF DEATH.

D 61329

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 928 N. Stricker ST. 16

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Nanma E. Spell.

## (a) RESIDENCE. NO. 928 N. Stricker ST. 16

(Usual place of abode)

## WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female colored

## 4 COLOR OR RACE

## 5 Single, Married, Widowed,

or Divorced (write the word)

Divorced

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Oct 15 1921

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

2

14

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Domestic

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

City

## 10 NAME OF FATHER

Frank Hall

## 11 BIRTHPLACE OF FATHER (city or town),

(State or country)

City

## 12 MAIDEN NAME OF MOTHER

Mary A. Davis

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

City

## 14

Informant

(Address)

Frank Hall  
928 N. Stricker St.

## 15

Filed

FEB 15 1922

ROBERT K. KRAUTER  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb 10 1922

I HEREBY CERTIFY, That I attended deceased from

Feb 10 1922 to Feb 14 1922

that I last saw her alive on Feb 14 1922

and that death occurred, on the date stated above, at 8:20 P. M.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. 5 ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leo H. Langenbach M. D.

(Address) 22-15 N. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Western Star Feb 16 1922

## 20 UNDERTAKER

## ADDRESS

Samuel Wright 1349 Mary



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61330

D 61330

## CERTIFICATE OF DEATH.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 ST. WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

WARD

(If non resident give city or town and State)

How long in U. S., if of foreign birth?

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

FEB 15 1922

ROBERT R. KRAUTER, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from 1-4, 1922, to 2-14, 1922.

that I last saw him live on 2-14, 1922.

and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of glands of neck, both sides -

CONTRIBUTORY (Secondary) (duration) 9 yrs. mos. ds. Air Embolus

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 1-5-22

Was there an autopsy? No - 2-14-22

What test confirmed diagnosis? Microscopic (Signed) W. C. Caldwell, M. D. (Address) St. Agnes Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park

2/17/1922

20 UNDERTAKER

Wm. Cook, 502 E. North ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61331

## CERTIFICATE OF DEATH.

31

D 61331

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 44 Parkin

ST.: 18 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Bradunas

(a) RESIDENCE No. 44 Parkin

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Feemal 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Marred

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Antaney Bradunas

6 DATE OF BIRTH (month, day, and year) Noknow

7 AGE 30 Years Months Days If LESS than 1 day, hrs. or min.

Noknow

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particularly kind of work

Housekeeper 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lithuania  
(State or country)

10 NAME OF FATHER John Zitkus

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Marth Lekauckas

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Lithuania

14

Informant: Antaney Bradunas  
(Address) 44 Parkin Street

15

FEB 15 1922 ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1922

17 I HEREBY CERTIFY, That I attended deceased from

Feb. 1, 1922, to Feb. 14, 1922,

that I last saw him alive on Feb. 14, 1922,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)Exhaustion  
(duration) 6 yrs. mos. ds.18 Where was disease contracted  
if not at place of death? Dont Know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Herbert C. Blake, M. D.

, 19 (Address) 1014 W. Fa. Fayette

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

ST. Stanislaus

Feb 15, 1922

20 UNDERTAKER

ADDRESS

John Lekauckas 425 S. Park St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 61332

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61332

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 316 S Vincent ST., 19 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE No. 316 S Vincent ST., 19 WARD(Usual place of abode) 44 yrs. 40 mos. 4 ds. (If non-resident give city or town and State)  
Length of residence in city or town where death occurred

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Susan Carter6 DATE OF BIRTH (month, day, and year) Not known7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
70

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) 04

(c) Name of employer

9 BIRTHPLACE (city or town) Prince George's Co  
(State or country) Ind.10 NAME OF FATHER Louis William Carter11 BIRTHPLACE OF FATHER (city or town) Prince George's  
(State or country) Ind.12 MAIDEN NAME OF MOTHER Not known13 BIRTHPLACE OF MOTHER (city or town) Not known  
(State or country)

14

Informant Clarence Figueroa  
(Address) 1513 N Carey St

15

FEB 15 1922 ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 19 22

17

I HEREBY CERTIFY, That I attended deceased from  
Mar 1, 19 21, to Feb 13, 19 22,  
that I last saw him alive on Feb 12, 19 22,and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial  
Nephritis(duration) 1 yrs. 0 mos. 0 ds.CONTRIBUTORY  
(Secondary)(duration) 0 yrs. 0 mos. 0 ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? 0 Date of 0Was there an autopsy? 0

What test confirmed diagnosis?

(Signed) E. Williams Fley, M. D.1922 (Address) 1928 Penna Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL mt Auburn Cem

DATE OF BURIAL

Feb 16 19 22

20 UNDERTAKER

Carl HollandADDRESS 1631Wm H Hill  
Inc

Exact statement of OCCUPATION is very important. See instructions on back of certificates.



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61333

D 61333

### PLACE OF DEATH

CITY OF BALTIMORE (No. *N. W. Condy* St. *11*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### 2-FULL NAME

*William H. Hayden*

(Residence in Baltimore: No. *331 N. Biddle St.*)

St. *25* yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

#### 3-SEX,

*male*

#### 4-COLOR OR RACE,

*colored*

#### 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

*married*

#### 6-DATE OF BIRTH,

*Jan. 18, 1869*  
(Month) (Day) (Year)

#### 7-AGE,

*53* yrs. *25* mos. ds.

If LESS than 1 day, .... hrs. or .... min.?

#### 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

*waiter*  
*086*

#### 9-BIRTHPLACE, (State or Country),

*Va.*

#### 10-NAME OF FATHER,

*Sco. Hayden*

#### 11-BIRTHPLACE OF FATHER (State or Country),

*Va*

#### 12-MAIDEN NAME OF MOTHER

*Anna Bealy*

#### 13-BIRTHPLACE OF MOTHER (State or Country),

*Va*

#### 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Robert R. Krauter*

(Address) *331 N. Biddle St.*

#### 15-

*FEB 15 1922*

*ROBERT R. KRAUTER,*

Burial Permit Clerk.

### CORONER'S CERTIFICATE OF DEATH.

#### 16-DATE OF DEATH,

*Feb. 12, 1922*  
(Month) (Day) (Year)

#### 17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*  
(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said *inquest*  
(Inquest, au-

*opsy* and that said deceased came to *his* death  
(topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH was as follows:

*Organic heart disease*

(Duration) .... yrs. .... mos. .... ds.

#### CONTRIBUTORY (Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed) *J. T. Harrison* M. D.

*Feb. 14, 1922* (Address) *2802 Edmonson St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

#### 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

#### Former or usual residence

#### 19-PLACE OF BURIAL OR REMOVAL,

*Laurel Cemetery*

#### DATE OF BURIAL,

*Feb. 15, 1922*

#### 20-UNDERTAKER

*Jno. M. Johnson*

#### ADDRESS

*1234 E. 5th St.*

D 61334

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31

D 61334

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO Municipal Tuberculosis Hospital 16 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Roberts

(a) RESIDENCE. NO 619 N. Brice st.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of John H. Roberts

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
52				

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Maryland

10 NAME OF FATHER John Mitchell

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

New York

12 MAIDEN NAME OF MOTHER Catherine Abur

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Maryland

14 Informant Hospital Records  
(Address) M.T.H.

15 FEB 15 1922 ROBERT A. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14, 1922

17 I HEREBY CERTIFY, That I attended deceased from  
January 4, 1922, to Feb. 14, 1922.  
that I last saw her alive on Feb. 13, 1922.

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY Tuberculosis of kidney

(Secondary) and bladder (duration) 1 yrs. 1 mos. ds.

18 Where was disease contracted  
if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis Badagliacchi M.D.

-14-1922 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral Cemetery 2/16/22

20 UNDERTAKER Chas. J. Evans &amp; Son 118 Wm. Royal

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 3 WARD)

## REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Connors(a) RESIDENCE. No. 210 S. High st.

ST. .... WARD. ....

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. .... ds. How long in U. S., if of foreign birth Unknown mos. .... ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
----------------------	---------------------------------	--

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day. .... hrs. or .... min.
	<u>57</u>			

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work Laborer(b) General nature of industry,  
business, or establishment in  
which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town)  
(State or country) Ireland10 NAME OF FATHER James Connors11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Ireland12 MAIDEN NAME OF MOTHER Elizabeth McNally13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Ireland14 Informant Hospital Records  
(Address) M.T.H.15 Filed 18913, 19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11, 1922

17 I HEREBY CERTIFY, That I attended deceased from  
Oct. 20, 1919, to Feb. 11, 1922  
that I last saw him alive on Feb. 11, 1922  
and that death occurred, on the date stated above, at 10.10 p.m.  
The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(duration) 2 yrs. 6 mos. .... ds.CONTRIBUTORY  
(Secondary)

(duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted  
if not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis T.B. in sputum, X-ray(Signed) Francis J. Delagiac M. D.2-12-22 (Address) Municipal Tbc. Hospital.\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF 1922JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

ADDRESS

Commissioner Health,

CAUSE OF DEATH in plain terms, so that it may be properly classified. Enter statement of OCCUPATION is very important. See instructions on back of certificates.

## D 61336

## Registered No. C.....

City of BALTIMORE: (No. Mercy Hospital. St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Joseph Wilkerson.(C).....

(Residence in Baltimore: No. .... Fourth Ave. & 3rd St. Fairfield St.; yrs., .... mos. .... ds.)

## CORONER'S CERTIFICATE OF DEATH.

3-SEX,  Male.	4-COLOR OR RACE,  Colored.	5-Single, Married, <i>Married</i> Married, Widowed, or Divorced, (Write the word.)
---------------------	----------------------------------	--

6-DATE OF BIRTH. Do not know. 1.  
(Month) (Day) (Year)

7-AGE, 55 yrs. -- mos. --- ds. If LESS than 1 day, --- hrs. or --- min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work..... Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,  
(State or Country),

10-NAME OF FATHER,	Do not know.
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11. BIRTHPLACE OF FATHER. (State or Country),	Do not know.
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<div style="writing-mode: vertical-rl; transform: rotate(180deg);"> <b>PREPARE</b> </div>	<b>12-MAIDEN NAME</b> <b>OF MOTHER,</b>	Do not know.
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13-BIRTHPLACE OF MOTHER, (State or Country).	Do not know.
--	--------------

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marie Wilkerson (C). (wife).

(Address) Fourth Ave. & 3rd St., Fairfield

FEB 15 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

16-DATE OF DEATH, February 4th, 1922, 192....  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest... & ... Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said... Inquest. (Inquest, autopsy or inquiry.) & Autopsy... find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Intra cranial Hemorrhage due to a  
fracture of the skull. struck by  
an iron bar. Homicide.

(Duration) yrs. mos. ds

CONTRIBUTORY  
(Secondary)  
..... (Duration) ..... yrs. mos. ds.  
(Signed) ..... M. D.  
(Coroner)  
Feb. 13 1922 (Address) 1017 S. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

**18-LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients, or Recent Residents).

<b>At place of death.....</b>	<b>yrs.....</b>	<b>mos.....</b>	<b>ds.....</b>	<b>In the State.....</b>	<b>yrs.....</b>	<b>mos.....</b>	<b>ds.....</b>
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Where was disease contracted, if not at place of death?.....  
 Assaulted at Standard Guano Co. 2/3/22  
 Former or usual residence...Curtis Bay.....

PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,

NS HOPKINS HOSPITAL 12

20-UNDERTAKER.	ADDRESS
----------------	---------

Commissioner, Health, 15 192

STATE CAUSE OF DEATH in plain terms, so that it may be properly understood.  
is very important. See instructions on back of certificate.



261337 HEALTH DEPARTMENT—CITY OF BALTIMORE 261337  
31

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2013 Lincoln St. 6 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. 2013 Lincoln St. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Evans

6 DATE OF BIRTH (month, day, and year) Feb 8 1900

7 AGE Years 22 Months Days 5 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cashier 086

(b) General nature of industry, business, or establishment in which employed (or employer) Theatre

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Boston

10 NAME OF FATHER John Dornick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Boston

12 MAIDEN NAME OF MOTHER Theresa Placide 1-3, 1922

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Boston

14 Informant John Dornick (Address) 2013 Lincoln St.

FEB 15 1922

ROBERT R. KRAUTER, Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1922, to Feb 13, 1922, that I last saw him alive on Feb 12, 1922, and that death occurred, on the date stated above, at 1 P. M. The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY acute edema lungs (Secondary) (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings (Signed) M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Redeemer Feb 16 1922

20 UNDERTAKER ADDRESS

Frank Jackson 1916 Ashland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

D 61338

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61338

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2410 Fair Ave* ST., *1* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Edward Leo Riley*(a) RESIDENCE No. *2410 Fair Ave.*, ST., *1* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *September 8-1918*7 AGE Years *3* Months *5* Days *6* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *At Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore Md.*10 NAME OF FATHER *Edward Leo Riley*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto Md*12 MAIDEN NAME OF MOTHER *Helena Bobbitz*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore Md.*14 Informant *Edward L. Riley* (Address) *2410 Fair Ave.*15 Filed *FEB 15 1922* *ROBERT H. KRAUTER,* Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 14 1922*17 I HEREBY CERTIFY, That I attended deceased from *Feb. 6*, 1922, to *Feb. 13*, 1922, that I last saw him alive on *Feb. 13*, 1922,and that death occurred, on the date stated above, at *6 45* A.m.

The CAUSE OF DEATH\* was as follows:

*Broncho-Pneumonia*(duration) yrs. mos. *9* da.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Henry B. Healy*, M. D.*7/15, 1922* (Address) *2604 Potomac St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Mount Carmel Cem.**Feb. 16 1922*

20 UNDERTAKER

ADDRESS

*H. Sander Sons**1710 Fleet St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as, "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61339

D 61339

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

2. FULL NAME

(a) RESIDENCE

(Usual place of abode)

Length of residence in city or town where death occurred

ST.,

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

FEB 15 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1922

17

I HEREBY CERTIFY, That I attended deceased from 2/10/1922 to 2/14/1922, that I last saw her alive on 2/13/1922, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 3. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-ROVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 4617 Dundas Road ST. 15 WARD)

## 2-FULL NAME

Nennetta Clay Reid(a) RESIDENCE. NO. 4617 Dundas Road ST. 15 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) widow5a If married, widowed, or divorced, by what name? (or) WIFE of Dr. Robt M. Reid6 DATE OF BIRTH (month, day, and year) Feb 11 19 22 7 AGE 74 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Fredrickstadt (State or country)10 NAME OF FATHER Benz F. Wingfield11 BIRTHPLACE OF FATHER (city or town) Va (State or country)12 MAIDEN NAME OF MOTHER Rebecca Burrows13 BIRTHPLACE OF MOTHER (city or town) England (State or country)14 Informant Ms. N. G. Phillips (Address) 4617 Dundas Road15 FEB 15 1922ROBERT R. KRAUTER  
Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 19 2217 I HEREBY CERTIFY, that I attended deceased from Feb 11 19 22, to Feb 14 19 22, that I last saw her alive on Feb 13 19 22, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH\* was as follows:

Paralytic(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.18 Where was disease contracted if not at place of death? noDid an operation precede death? no Date of —Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Meek

M. D.

19 (Address) 2 W. Balaban

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS 1940Green Mount Cem.  
Harry W. EhlerFeb 16 19 22  
W. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61341

D 61341

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 S. Gilman ST.; 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Zell(a) RESIDENCE. NO. 204 S. Gilman ST.; WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widower5a If married, widowed, or divorced, HUSBAND of Carrie Zell (or) WIFE of6 DATE OF BIRTH (month, day, and year) July 7 18537 AGE Years 68 Months 7 Days 6 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Silver Plater

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B.O.R. Reed9 BIRTHPLACE (city or town) Pa (State or country)10 NAME OF FATHER William Zell11 BIRTHPLACE OF FATHER (city or town) Germey (State or country)12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant William H. Zell (Address) 204 S. Gilman15 Filed Robert P. Harrison

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 192217 I HEREBY CERTIFY, That I attended deceased from Jan 1921, to Feb 1922, that I last saw him alive on Feb 13 1922, and that death occurred, on the date stated above, at 8 15 m.

The CAUSE OF DEATH\* was as follows:

Chronic Bronchopneumonia(duration) 2 yrs. mos. da.CONTRIBUTORY Uremia (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? YesWhat test confirmed diagnosis? Clinical(Signed) Edward Macdonald M. D.7/18 1922 Address) 24 W. Fullen St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park Cem Feb 16 1922

20 UNDERTAKER

for foerden. Son 2178. Bon

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

D 61342 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61342

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Kesterson(a) RESIDENCE. No. 3704 Mt. Pleasant ave. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Separated

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
52				

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland10 NAME OF FATHER Wm. A. Kesterson11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Virginia12 MAIDEN NAME OF MOTHER Winifred Fullarn13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) England14 Informant Hospital Records  
(Address) M. T. H.15 Robert P. Harrison

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14, 1922

17 I HEREBY CERTIFY, That I attended deceased from  
January 21, 1922, to Feb. 14, 1922.  
that I last saw him alive on Feb. 14, 1922.  
and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(duration) yrs. 8 mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? UnknownDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? T. B. in sputum, X-ray(Signed) Francis L. Padagliano M. D.2-15-22 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Cross Cem. N. YorkFeb 18 1922

20 UNDERTAKER

ADDRESS

John Henry Co2008 Chelam

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61343

## CERTIFICATE OF DEATH.

D 61343

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *127 E. West* ST. *24<sup>th</sup>* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

*Joseph A. Unger*

## (a) RESIDENCE NO.

*127 E. West*ST. *24<sup>th</sup>* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *39* yrs. *4* mos. *5* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a-10 months, widowed, or divorced

HUSBAND of

*Amanda Unger*6 DATE OF BIRTH (month, day, and year) *Oct. 9, 1882*7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*39* *4* *5*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Printer 16<sup>3</sup>*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Townson & Grace*

9 BIRTHPLACE (city or town) (State or country)

*Balto, Md*

## 10 NAME OF FATHER

*Bernard Unger*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balto Md*

## 12 MAIDEN NAME OF MOTHER

*Mary Hennig*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*

## 14

Informant (Address)

*Amanda Unger*  
*127 E. West St.*

## 15

Date

*Feb 15 1922**Robert P. Harrison*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 14 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 6*, 1922, to *Feb 14*, 1922,that I last saw him alive on *Feb 14*, 1922,and that death occurred, on the date stated above, at *5:30 P* m.

The CAUSE OF DEATH\* was as follows:

*Acute articular rheumatism*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

*Endocarditis*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Phys*

(Signed)

*Wm. B. H. H. H.*

M. D.

Address

*1319 Light St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*E. J. B. Harle**115 E. West St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



D 61344 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61344

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2011 Oakley St. ST. 16 WARD)

## 2-FULL NAME Thomas Carl McKelvey

(a) RESIDENCE, NO. 2011 Oakley St. ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 26 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 22 1917

7 AGE

5

Months

26

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto City Maryland

10 NAME OF FATHER

Marshall H McKelvey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Cockeysville Maryland

12 MAIDEN NAME OF MOTHER

Nellie C. Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Toulesmouth Virginia

14

Informant (Address)

Marshall H McKelvey 2011 Oakley St.

15

Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 31 1922, to Feb 13 1922,

that I last saw him alive on Feb 13 1922,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH\* was as follows:

Streptococcus Septicemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis

(Signed) J. P. Jones, M. D.

19 (Address) 1837 E. Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Jesus Church Balto

Feb 16 1922

20 UNDERTAKER

ADDRESS

A. S. Manshall 3539 Fall Rd

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Every death or information which may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D 61345

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61345

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1)

2-FULL NAME

(Residence in Baltimore: No. 1)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOW, OR DIVORCED (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Registrar.

REGISTERED No. C

ST. 3 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. 1 ds.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

And that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Accidentally Crushed to death by train

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry G. M. P. (Coroner.)

Oct 15 1912 (Address) 1507 1/2 E. 1st St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs... mos... ds. In the State... yrs... mos... ds.

Where was disease contracted, if not at place of death?...

Former or usual residence Seaford, Del.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

D 61346

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61346

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE:

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. .... St.; yrs., .... mos., .... ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

## 8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

(Address),

15-

Filed

1922

5-1922

Robert P. Harrison,

Permit Clerk.

Registrar

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

1 HEREBY CERTIFY, that I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH was as follows:

CONTRIBUTORY (Secondary)

(Signed)

(Address)

\*State the Disease Causing Death, or, in deaths from violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, .... yrs., .... mos., .... ds. In the State, .... yrs., .... mos., .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

D 61347 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61347

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2058 Linden Ave. 13 ST., WARD)

## 2. FULL NAME

(a) RESIDENCE No. 2058 Linden ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

75 yrs. 5 mos. 13 ds.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Elizabeth Toberer

6 DATE OF BIRTH (month, day, and year)

Sept. 1, 1846

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

75

5

13

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Advertising Bus

(b) General nature of industry, business, or establishment in which employed (or employer)

1086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Conrad Toberer

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

11

14

Informant (Address)

Mrs Elizabeth Toberer 2058 Linden Ave

15

Filed

Robert E. Garrison,

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1922

17 Aug - 8 - 21

HEREBY CERTIFY, That I attended deceased from

Aug 8, 1922 to Feb 14, 1922

that I last saw him alive on Feb 13, 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Arterio-sclerosis -

(duration) 7 yrs. 1 mos. 13 ds.

CONTRIBUTORY uremia - myocarditis (Secondary)

(duration) yrs. 1 mos. 13 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical

(Signed)

J. Frederick Lutz, M. D.

2-14-1922 (Address) 2040 E. 1st St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Wm. J. Pickens 2040 E. 1st St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

5 1922

Burial Permit 2221



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoncum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

No hemorrhage. Chronic  
nephritis.  
Dr. Leitch  
Entaw Place

D 61348

HEALTH DEPARTMENT-CITY OF BALTIMORE

D 61348

## CERTIFICATE OF DEATH

## PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Francis & Chase* ST. *90* WARD)2-FULL NAME *Miss Kate Lee*(Residence in Baltimore: No. *Cor. Forrest & Chase* St. *50* yrs. *50* mos. *50* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

*Female*

4-COLOR OR RACE

*Colored*5-SINGLE, *Single*~~MARRIED~~~~WIDOWED~~~~OR DIVORCED~~

(Write the word)

6-DATE OF BIRTH

*Feb 29*

(Month)

(Day)

(Year) *1826*

7-AGE

*95*

yrs.

*11*

mos.

*15*

ds.

If LESS than  
1 day, .... hrs.  
or .... min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

*Not any*

(b) General nature of industry, business, or establishment in which employed (or employer)

*None*

9-BIRTHPLACE

(State or country)

*Frederick Md.*

10-NAME OF FATHER

*Charles Lee*

PARENTS

11-BIRTHPLACE OF FATHER

(State or country)

*Maryland*

12-MAIDEN NAME OF MOTHER

*Catherine Lee*

13-BIRTHPLACE OF MOTHER

(State or country)

*Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Mother Margaret Mary*

(Address)

*St. Francis' Current*

15-

*Robert F. Harrison,*

Filed

191

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

*2*

(Month)

*14*

(Day)

*1922*

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Jan 20, 1922 to Feb 14, 1922*that I saw her alive on *Feb 14, 1922*and that death occurred, on the date stated above, at *3:35 pm*

The CAUSE OF DEATH\* was as follows:

*Mitral Insufficiency*  
*To my knowledge* (Duration) *4* yrs. *4* mos. *4* ds.

Contributory

(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed) *Mary F. Voeglein* M. D.  
*Feb 15, 1922* (Address) *1028 Valley St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

In the

State

yrs.

mos.

ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Cathedral Cemetery**7/17/22, 1922*

20-UNDERTAKER

ADDRESS

*Felix B. Dyer 102 & Mulberry St*

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FEB 15 1922

Municipal Permit Clerk

D 61349

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61349

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1513 Mt. Royal Ave. ST. 14th WARD)

## 2-FULL NAME

Cecilia Weinberg

## (a) RESIDENCE NO.

1513 Mt. Royal Ave. ST. 14th WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widow

## 5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

Moses Weinberg

## 6 DATE OF BIRTH (month, day, and year)

June 17 1852

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

69 5 16

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Danzig

## 10 NAME OF FATHER

Jacob Loeb

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Annie Loeb

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

## 14

Informant (Address)

Mrs. S. Fishman  
1513 Mt. Royal Ave.

## 15

Robert E. Harrington

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb. 14 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan 1st, 1922, to Feb. 14th, 1922.that I last saw him alive on Feb. 14th, 1922.and that death occurred, on the date stated above, at 7 A. M.

The CAUSE OF DEATH\* was as follows:

Reddena of the Lungs

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Organic disease of heartMitral valves (duration) 5 yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of noneWas there an autopsy? noWhat test confirmed diagnosis? Clinical only(Signed) Eugene Douglas, M. D.19-1922 (Address) 830 W. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

Bonville Pa2/16/ 1922

## 20 UNDERTAKER

David SandheimADDRESS  
118 Mt. Royal Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

B 15 1922

D 61350

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61350

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2438 E Chase ST., 8 WARD)2. FULL NAME John T Bents(a) RESIDENCE NO. 2438 E Chase ST., 8 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Barbara Bents6 DATE OF BIRTH (month, day, and year) Aug 31st 18627 AGE Years 60 Months 5 Days 14 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Orleans10 NAME OF FATHER Dont know11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont know12 MAIDEN NAME OF MOTHER Dont know13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know

14

Informant (Address) Barbara Bents  
2438 E Chase St

15

Robert E. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14th 192217 I HEREBY CERTIFY That I attended deceased from Dec 15, 1921 to Feb 14, 1922 that I last saw him alive on Feb 13, 1922and that death occurred, on the date stated above, at 4, 9, m.

The CAUSE OF DEATH\* was as follows:

Pulmonary TB.

(duration) yrs. mos. ds.

CONTRIBUTOR (Secondary) Pulmonary TB.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknownDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? findings(Signed) F. F. P. M. D.

19

(Address) 800 North 2nd St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Holy Redeemer Church

DATE OF BURIAL

20 UNDERTAKER Robt L Turner Inc.ADDRESS 1442 8th Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

815 1922

Burial Permit Clerk.



Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61351

(Behrens)  
HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ 181-D 61351

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 20 n modern ST)

WARD 6

FULL NAME

George Behrens

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2207 Lamley St,

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male  
4-COLOR OR RACE white  
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)  
6-DATE OF BIRTH, Jan 7, 1878  
(Month) (Day) (Year)

7-AGE 43  
46 yrs. 6 mos. ds.  
If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. China Pack  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE (State or Country) Baltimore City

10-NAME OF FATHER Jacob Behrens

11-BIRTHPLACE OF FATHER (State or Country) Baltimore City

12-MAIDEN NAME OF MOTHER Magdalena Hansa

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Jacob Behrens

(Address) 2207 Lamley St

15- Robert F. ...

Filed 1912 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Feb 12, 1912  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

THE CAUSE OF DEATH? was as follows: probably accidental.  
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Duration yrs. mos. ds.

(Signed) M. D. 2-7-12 (Address) ...

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, 5th Reformed Ch. DATE OF BURIAL, Feb 16, 1912

20-UNDERTAKER Peter Nicolaas ADDRESS 2046 Eastern

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61352

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *1249 Columbia* ST. *179* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. *1249 Columbia* ST. *179* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *13* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? *0* yrs. *0* mos. *0* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *married*6a If married, widowed, or divorced HUSBAND of (or) WIFE of *Estelle Gately*6 DATE OF BIRTH (month, day, and year) *June 20, 1886*7 AGE Years *36* Months *0* Days *4* If LESS than 1 day, *0* hrs. *0* min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Musician*(b) General nature of industry, business, or establishment in which employed (or employer) *086*

(c) Name of employer

9 BIRTHPLACE (city or town) *New Jersey* (State or country)10 NAME OF FATHER *Joseph M. Gately*11 BIRTHPLACE OF FATHER (city or town) *England* (State or country)12 MAIDEN NAME OF MOTHER *Mary Melah*13 BIRTHPLACE OF MOTHER (city or town) *England* (State or country)

14

Informant (Address) *Mrs. Estelle Gately*  
*1249 Columbia St.*

15

Filed *Robert P. Harrison*, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 13, 1922*17 I HEREBY CERTIFY, That I attended deceased from *days*, 19 *22*, to *Feb 13, 1922*that I last saw him alive on *Feb 13, 1922*and that death occurred, on the date stated above, at *6 P.* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Interstitial Nephritis*(duration) *4* yrs. *0* mos. *0* ds.CONTRIBUTORY (Secondary) *Uremia*(duration) *7* yrs. *0* mos. *0* ds.

18 Where was disease contracted? If not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Geo. S. McKee*, M. D.  
(Address) *1249 Columbia St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Balt. County**Feb 16, 1922*

20 UNDERTAKER

ADDRESS

*Geo. Lembeck & Co. 647 N. B. St.*

FEB 15 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 61353

HEALTH DEPARTMENT—CITY OF BALTIMORE

61353

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 4222 Vermont ST.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul S. Federline

(a) RESIDENCE. NO. 4222 Vermont ST.

(Usual place of abode) (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 11. 22

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Name (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

10 NAME OF FATHER John Federline

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co.

12 MAIDEN NAME OF MOTHER Mary M. Federline

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co.

14 Informant (Address) Mrs. G. Federline 4222 Vermont St.

15 Filed Robert P. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1922, to Feb. 15, 1922, that I last saw him alive on Feb. 14, 1922, and that death occurred, on the date stated above, at 5 A. M.

The CAUSE OF DEATH\* was as follows:

Pneumonia following at 80 Months (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Was there an autopsy? No

What test confirmed diagnosis? (Signed) Howard W. Jaworski, M. D.

2-15-22 (Address) 2-15-22

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

New Cathedral Cemetery 2/16 1922

20 UNDERTAKER ADDRESS

John W. Bonkline 924 E. Eager St.

815 1922

Burial Permit Clerk.





D 61355

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61355

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1729 Abbotston

ST., 9<sup>th</sup> WARD)

## 2. FULL NAME

(a) RESIDENCE NO. 1729 Abbotston

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds.

ST., 9<sup>th</sup> WARD

(If non-resident, give city or town and State)

How long in U. S., if of foreign birth? 2 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed or Divorced, (write the word)

Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

Caroline Lachmann

6 DATE OF BIRTH (month, day, and year)

November 2<sup>nd</sup> 1848

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

73

3

12

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Butcher

013

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Carl Lachmann

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Caroline S. Lachman 1729 Abbotston st

15

FEB 16 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1922 to Feb 14 1922, that I last saw him alive on Feb 14 1922, and that death occurred, on the date stated above, at 6:50 P. m.

The CAUSE OF DEATH\* was as follows:

Valvular Disease of the heart

CONTRIBUTORY (Secondary) Valvular Disease of the heart (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 70

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Personal Autopsy

(Signed)

John W. Westbrook, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Parkwood Cemetery

20 UNDERTAKER

George Schilling &amp; Sons

DATE OF BURIAL

Feb 17<sup>th</sup> 1922

ADDRESS

116 E Monument st

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61356

## CERTIFICATE OF DEATH.

D 61356

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital.ST.: 26 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Barnes(a) RESIDENCE. No. Unknown

(Usual place of abode)

ST. Unknown WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
74	--	--	--	--

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hostler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.  
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown  
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)14 Informant Hospital Records,  
(Address) Municipal Hospital.15 FEB 16 1922 ROBERT R. KRAUTER,  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 19 2217 I HEREBY CERTIFY, That I attended deceased from  
August 14 1920, to February 14 19 22.that I last saw him alive on February 13 19 22.and that death occurred, on the date stated above, at 7:15 A.M.

The CAUSE OF DEATH\* was as follows:

Pneumonia(duration) yrs. mos. 2 ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Clyde McNeill M. D.2/14/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

AsburyFeb 16 19 22

20 UNDERTAKER

ADDRESS 1502John W HendersonC McNeill

CAUSE OF DEATH in plain terms, so that it may be properly translated. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61357

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

St. Joseph's Hospital

ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME

Anna E. Burloge

(a) RESIDENCE, No.

600 E. Eager

ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos.

How long in U. S., If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND or (or) WIFE of

George E. Burloge

6 DATE OF BIRTH (month, day, and year)

Nov 11/1887

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

44

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Patience Hard

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Mary Finnan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant

(Address)

Mr. George E. Burloge

600 E Eager

15

Filed

19

FEB 16 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14 1922, to Feb. 14 1922,

that I last saw him alive on Feb. 14 1922, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH\* was as follows:

Myocardial Infarct.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. strangulated hernia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Feb. 14-22

Was there an autopsy? No.

What test confirmed diagnosis? P S &amp; S.

(Signed) Harold C. Pellabury, M. D.

19 (Address) 415 Cadmus Rd.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cemetery

Feb. 17 1922

20 UNDERTAKER

ADDRESS

Henry Horch Son

1301 E Eager

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Bay View* ST. *10* WARD)

2-FULL NAME *Florence E Smith*

(Residence in Baltimore: No. *607 E Chase*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *10* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Female*

4-COLOR OR RACE

*White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

*Married*

6-DATE OF BIRTH,

*Dec 31, 1887*  
(Month) (Day) (Year)

7-AGE,

*34 yrs. 1 mos. 14 ds.*

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

*At home*

9-BIRTHPLACE,

(State or Country).

*Little Tan Pa*

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER,

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*George E Smith*  
(Address) *607 E Chase St*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Feb 15, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *investigation* (Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Pulmonary tuberculosis*  
*about 1 year* (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *Henry W. Smith* M. D.  
*Feb 15, 1922* (Address) *1800 4th Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?...

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

*Woodlawn Feb 18, 1922*

20-UNDEFTAKER

ADDRESS

*William Beck 522 E North Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION if very important. See instructions on back of certificate.

1 FEB 16 1922

Filed

101

ROBERT B. KRAUTER Registrar.

Burial Permit Clerk.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61359

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mad General Hospital* ST. *9* WARD)2-FULL NAME *Otis T Miles*(a) RESIDENCE. NO. *1546 Asplund St.* ST. *9* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *50 Years* mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*W*

5 Single, Married, Widowed, or Divorced (write the word)

*Divorced*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb. 24 - 1854*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*67**11**22*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Umbrella Maker*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balto Co Md*10 NAME OF FATHER *Nelson Miles*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balto Co Md*12 MAIDEN NAME OF MOTHER *Alberie Mayes*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balto Co Md*

14

Informant (Address)

*Nelson C Miles 1215 E. North Ave.*

15

Filed

*ROBERT R. KRAUTER*

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 15 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*2/12/22* 19 *21/5/22* 19that I last saw him alive on *2/10/22*and that death occurred, on the date stated above, at *8:40 a.m.*

The CAUSE OF DEATH was as follows:

*Coronary Failure*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

*10* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? *Clin. Symptom*

(Signed)

. 19 (Address)

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Jessop Cem. Ashland**Feb 17 1922*

20 UNDERTAKER

ADDRESS

*Wm Cook 502 E North*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

FEB 16 1922

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary freman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Probably chronic*

D 61360 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 Little Second St. ST., 3 WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

35 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Wife

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

33 Years

Months

Days

If LESS than

1 day, hrs.

or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Harford Co. Md.  
lives in Balt-4 years

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant

(Address)

Mary Janney  
729 Little Second St.

15

Filed

ROBERT R. KRAUTER,Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Febr. 13 1922

17

I HEREBY CERTIFY, That I attended deceased from

December 30, 1921, to February 13, 1922that I last saw her alive on February 12, 1922and that death occurred, on the date stated above, at 6.35 A m.

The CAUSE OF DEATH\* was as follows:

apoplexyAsthma & Dropsy.

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Asthma & Dropsy

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Calvert Co., Md.

Did an operation precede death?

no

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1922

(Address)

729 Little Second St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Sandy Bottom CmsFeb 14 1922

20 UNDERTAKER

Tolson

ADDRESS

Mrs Robert A ElliottAshland

FEB 16 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61361

## CERTIFICATE OF DEATH.

D 61361

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Agel Women Home* ST.: *9* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Rose Thompson*(a) RESIDENCE. No. *1400 W Lexington* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *10* yrs. *6* mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *ALT*5 Single, Married, Widowed, or Divorced (write the word) *Wid*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 19, 1852*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*69**7**13*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Harford Co. Md*10 NAME OF FATHER *James L Korrell*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Harford Co. Md*12 MAIDEN NAME OF MOTHER *Kardelia*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Harford Co. Md*

14

Informant (Address) *Ella J Jones Matron*

15

FEB 16 1922

ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 14* 19*22*

17

HEREBY CERTIFY, That I attended deceased from *Feb 7*, 19*22*, to *Feb 14*, 19*22*.that I last saw him alive on *Feb 13*, 19*22*.and that death occurred, on the date stated above, at *6:20 A* m.

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *7* ds.(duration) yrs. mos. *1* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *No*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. Howard* M. D.  
*Feb 15 1922* (Address) *939 W Fayette St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Aberdeen Md*

DATE OF BURIAL

*Feb 17* 19*22*

20 UNDERTAKER

*George J Smith*ADDRESS *1000**9 Fayette St*

CAUSE OF DEATH in plain terms, so that it may be properly translated. See instructions on back of certificates.



D 61362

## HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 61362

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Agel Women Home* ST.: *19* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Jarvis J. T. Block*(a) RESIDENCE. No. *1400 W. Lexington* ST.: *19* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *85* yrs. *5* mos. *14* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Wid*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug 24 1886*7 AGE Years Months Days *85* *5* *14* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *000*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *T. B. Block*9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *Whitely Black*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore*12 MAIDEN NAME OF MOTHER *Harriet Hooper*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore*

14

Informant (Address) *Allen J. Jones*  
*M. A. Jones*

15

FEB 16 1922

ROBERT N. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 14 1922*17 I HEREBY CERTIFY, That I attended deceased from *Feb 14 1922* to *Feb 13 1922*that I last saw him alive on *Feb 13 1922*and that death occurred, on the date stated above, at *8 A. M.*

The CAUSE OF DEATH\* was as follows:

*Organic Disease of Heart*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *1*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *No*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. Norwood* M. D.Feb 19 (Address) *939 W. Fayette St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *St. Oliver's Cemetery*

DATE OF BURIAL

*Feb 18 1922*

20 UNDERTAKER

*George J. Smith*ADDRESS *1000**W. F. Foy*

D 61363

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61363

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *13* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. *827 N. 35th.* ST. *13* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *15* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, write the word *Widow*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Widow*6 DATE OF BIRTH (month, day, and year) *March 17, 1858*7 AGE Years *63* Months *10* Days *27* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *md.* (State or country)10 NAME OF FATHER *Henry Stables*11 BIRTHPLACE OF FATHER (city or town) *md.* (State or country)12 MAIDEN NAME OF MOTHER *Carrie Buck*13 BIRTHPLACE OF MOTHER (city or town) *md.* (State or country)

14

Informant (Address) *Mercy Hospital Records*

15

Filed

FEB 16 1922

19 ROBERT H. KRAUTER Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 14 1922*17 HEREBY CERTIFY, That I attended deceased from *Feb. 6, 1922* to *Feb. 14, 1922* that I last saw her alive on *Feb. 14, 1922* and that death occurred, on the date stated above, at *9:15 a.m.* The CAUSE OF DEATH was as follows:*atrophic curvatures*

CONTRIBUTORY (Secondary)

(duration) *?* yrs. mos. ds.(duration) yrs. mos. ds. *7*18 Where was disease contracted If not at place of death *Home*Date of *Feb. 10, 1922*Was there an autopsy? *no*What test confirmed diagnosis? *Findings, signs, symptoms*(Signed) *John J. Cronin, M.D.*19 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Gruid Ridge* DATE OF BURIAL *Feb. 16 1922*UNDERTAKER *Norace H. Burque* ADDRESS *363 Falls Rd.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61364

## CERTIFICATE OF DEATH.

H 5 D 61364

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital.

ST. 22 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Affie Scott

(a) RESIDENCE No. 118 Perry St.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
60	--	--	--	--

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Somerset Co.,  
(State or country) Maryland

10 NAME OF FATHER Levan Hayward

11 BIRTHPLACE OF FATHER (city or town) Somerset Co.,  
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Edna Purnell

13 BIRTHPLACE OF MOTHER (city or town) Somerset Co.,  
(State or country) Maryland14 Informant Hospital Records,  
(Address) Municipal Hospital.15 FEB 16 1922 ROBERT R. KRAUTER,  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13 1922

17 I HEREBY CERTIFY, That I attended deceased from February 9, 1922, to February 13, 1922, that I last saw her alive on February 12, 1922, and that death occurred, on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH\* was as follows:

General Carcinomatosis  
of abdominal viscera  
Primary lesion not determined  
Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Study  
(Signed) J. H. Brown, M. D.

2/13/22 Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Auburn Ct Feb 17 1922

20 UNDERTAKER ADDRESS

J. H. Brown &amp; Son 108 W. Montg.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

61365

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2205 E Fayette St., 6 WARD)

## 2-FULL NAME

Raymond Thornton Payley

## (a) RESIDENCE NO.

2205 E Fayette St., 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Feb. 14, 1922

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Balt Md

## 10 NAME OF FATHER

Raymond Harry Payley

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt Md

## 12 MAIDEN NAME OF MOTHER

Lillian Payley

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt Md

## 14 Informant (Address)

Raymond A. Payley  
2205 E. Fayette St.

## 15

Filed

19

ROBERT R. KRAUTER  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15, 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1922, to Feb. 15, 1922, that I last saw him alive on Feb. 15, 1922, and that death occurred, on the date stated above, at 10 P. M. The CAUSE OF DEATH\* was as follows:

Coronary Artery Heart  
disease  
1 day (duration) yrs. mos. 1 ds.

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? 20 Date of

Was there an autopsy? 20

What test confirmed diagnosis?

(Signed)

Daniel S. Fisher

M. D.

19

(Address) 332 S. Park Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Balt Lamon Cem.

## DATE OF BURIAL

Feb. 17, 1922

## 20 UNDERTAKER

H. Sander Sons

## ADDRESS

1710 E. 4th St.

Information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 16 1922

Burial Permit Clerk



D 61366

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61366

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No

885 P. Belvoir

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Viola Freund

## (a) RESIDENCE. No

505 P. Belvoir

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life yrs

mos

ds.

How long in U. S., if of foreign birth?

yrs

mos

ds

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

June 21 - 1918

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3

7

24

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

OOD

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore City Md

## 10 NAME OF FATHER

Charles Freund

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

## 12 MAIDEN NAME OF MOTHER

Marie Hurlow

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

## 14

Informant (Address)

Mrs. Mary Hartlove 505 P. Belvoir

## 15

Filed

FEB 16 1922

Burial Permit

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb. 15 1922

## 17

I HEREBY CERTIFY, That I attended deceased from Feb 11, 1922, to Feb 15, 1922, that I last saw her alive on Feb 15, 1922, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH\* was as follows:

Diphtheria.

CONTRIBUTORY (Secondary) Cardiac Paralysis. (duration) yrs. mos. 5 ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) Dr. Long M. D.

2/15, 1922 (Address) 2701 Eastern

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

1st Evangelical Bur

Feb 16 1922

## 20 UNDERTAKER

## ADDRESS

A. Sander Son

1710 North

D 61367 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61367

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (NO

ST., 18 WARD)

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

16

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

FEB 16 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-14 1922

17

I HEREBY CERTIFY, That I attended deceased from 1-30 1922 to 2-14 1922.

that I last saw <sup>the</sup> alive on 2-14 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Septicæmia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY Dermatitis Erythematosa Neon- (Secondary) atonum (duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) H. Harper M. D.

19 (Address) St. Agnes Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

W. M. Routson

230 N. Greene

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Not Luetia. No  
further history.*

*Thos. R. Shaw*  
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61368

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2 Maryland General Hospital* ST. *11-00* WARD)

## 2-FULL NAME

*Thomas R. Shaw*

## (a) RESIDENCE. NO.

*Westminster. Md. ST.*

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

4

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *married*

5a If married, widowed, or divorced

HUSBAND of

(or, WIFE of)

*Sarah Shaw*6 DATE OF BIRTH (month, day, and year) *June 19, 1862*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*59**7**26*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Druggist. 175*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

*Maryland.*

## 10 NAME OF FATHER

*Thomas Shaw*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Maryland.*

## 12 MAIDEN NAME OF MOTHER

*Jessie Krise*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Maryland*

## 14

Informant

(Address)

*Mrs. Thomas R. Shaw  
Westminster Md*

## 15

Filed

19

*FEB 16 1922**ROBERT H. KRAUTER,*

Registrar

Burial Permit Clerk,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 15 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb. 12, 1922, to Feb 15, 1922*that I last saw him alive on *Feb 15, 1922*and that death occurred, on the date stated above, at *10:52 P. M.*

The CAUSE OF DEATH\* was as follows:

*Perforated ulcer of  
Duodenum.*

(duration)

yrs.

mos.

5 ds.

## CONTRIBUTORY

(Secondary)

*General peritonitis*

(duration)

yrs.

mos.

5 ds.

## 18 Where was disease contracted

if not at place of death?

*Westminster Md.*

Did an operation precede death?

*yes*Date of *Feb. 13, 1922*

Was there an autopsy?

*yes*

What test confirmed diagnosis?

*Autopsy*

(Signed)

*John W. White* M. D.

19

(Address)

*211. General Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Westminster Md**Feb 18 1922*

## 20 UNDERTAKER

## ADDRESS

*W M Rounton**3258 W  
Wilkes*

CAUSE OF DEATH in plain terms, so that it may be properly translated. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61369

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *525 N. Eyster* ST. *5* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *525 N. Eyster* St. *45* yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*6-DATE OF BIRTH, *Unknown* 18*70*

(Month)

(Day)

(Year)

7-AGE, *52*

yrs. mos. ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Cook 021*(b) General nature of industry, business, or establishment in which employed (or employer), *Private Family*9-BIRTHPLACE, (State or Country), *St Mary Co.*10-NAME OF FATHER, *Plan*11-BIRTHPLACE OF FATHER (State or Country), *Md*12-MAIDEN NAME OF MOTHER, *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Medea Roland*(Address) *525 N. Eyster*

15-

Filed.....

191

ROBERT R. KRAUTER  
Registrar.

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Monday, Feb 14<sup>th</sup>, 1922*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Feb 5<sup>th</sup> 1922* to *Feb 14<sup>th</sup> 1922*, that I saw her alive on *Feb 12<sup>th</sup> 1922*, and that death occurred, on the date stated above, at *3:30 p.m.*

The CAUSE OF DEATH\* was as follows:

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) *Exhaustion*

(Duration).....yrs.....mos.....ds.

(Signed).....M. D. *W. H. H. H.**Feb 14<sup>th</sup>, 1922* (Address) *607 N. Charles*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Mary's*DATE OF BURIAL, *Feb 16<sup>th</sup>, 1922*20-UNDERTAKER, *James H. H. H.*ADDRESS *St. Mary's*

important. See instructions on back of certificate.

D 61370

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.:

WARD)

2-FULL NAME

Mr Max Poliakoff

(a) RESIDENCE. No.

2 N Ave

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos.

ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

2/15/22

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

28

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Jewelry Salesman

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Obb

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Russia  
Mendle poliakoff

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia  
Bella Poliakoff

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant  
(Address)Raphel Poliakoff  
3749 Quakerstown Rd

15

Filed

FEB 16 1922

ROBERT R. KRAUTER  
Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

2/15/22

17

I HEREBY CERTIFY, That I attended deceased from

2/14

1922, to

2/15

1922

that I last saw him alive on 2/15, 1922

and that death occurred, on the date stated above, at 7:45 A. M.

The CAUSE OF DEATH\* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Moses Seelman

M. D.

. 19 (Address)

Hebrew Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Rosedale

Feb 16, 1922

20 UNDERTAKER

ADDRESS 1127

Max Linson

E. Balto 5x

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61371

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S Veterans Hospital #56

CITY OF BALTIMORE: (No. Ft. McHenry, Baltimore, Md. ST., WARD)

2-FULL NAME Bradley, Thomas B.

(a) RESIDENCE No. Ft. McHenry, Md..

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mrs. Thomas B. Bradley

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 25 -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Ga.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant E.T. Rosenbrock (Address)

15 FEB 16 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/14/22 19

17 I HEREBY CERTIFY, That I attended deceased from 2/7/22, 19, to 2/7/22, 19, that I last saw him alive on 2/14/22, 19,

and that death occurred, on the date stated above, at 8.25 P.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia, lobar

Unknown (duration) yrs. mos. da.

CONTRIBUTORY Cardiac insufficiency (Secondary)

Unknown (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. N. Gordon, M. D.

2/16 1922 Address Ft. McHenry, Md..

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL

National Cemetery 2/16 1922

UNDERTAKER

J. Linsor + Bros E. Baltes

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicidal*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Resident of Balto.*  
*Brooklyn, Md.*



*Hobart E. Gattis*  
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61372

## CERTIFICATE OF DEATH.

31 D 61372

1-PLACE OF DEATH U.S. Veterans Hospital #55

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. *Ft. McHenry* Baltimore, Md. St., *7* WARD)2-FULL NAME *Gattis, Hobart E.*(a) RESIDENCE NO. *Ft. McHenry ? Baltimore, Md. St.* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. Now long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

*Male Colored Married*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Mrs. Hobart E. Gattis*6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE Years Months Days If LESS than 1 day, ...hra. or ...min.

*24*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer*(b) General nature of industry, business, or establishment in which employed (or employer) *Unknown*(c) Name of employer *Unknown*

9 BIRTHPLACE (city or town) (State or country)

*Md.*10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Unknown*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*

14

Informant *E.T. Rosenbrock*  
(Address) *Registrar*

15

FEB 16 1922 ROBERT R. KRAUTER  
Filed, 19 Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/15/22* 19

17

I HEREBY CERTIFY, That I attended deceased from

*1/17/22*, 19, to *2/15/22*, 19.that I last saw him alive on *2/15/22*, 19.and that death occurred, on the date stated above, at *2.10 P.m.*

The CAUSE OF DEATH\* was as follows:

*Tuberculosis chronic pulmonary Far Adv. active**Unknown* (duration) yrs. mos. ds.CONTRIBUTORY *Unknown*  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Unknown*Did an operation precede death? *No* Date of --Was there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *F.N. Gordon* Surgeon (R.M.D.)*2/16/22* (Address) *Ft. McHenry, Md..*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*National Cemetery*

20 UNDERTAKER

*S. Guirra & Co*

DATE OF BURIAL

*2/16 1922*ADDRESS *1127 E**Balto. St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name organ; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Residence 1014 N.  
Wolfe St.*

D 61373

## HEALTH DEPARTMENT—CITY OF BALTIMORE

002  
D 61373

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. *11* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. *St. Paul Apts* ST. *(Resident)* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *0* yrs *0* mos. *7* ds.How long in U. S., if of foreign birth? *0* yrs *0* mos. *7* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *(Single)*6 DATE OF BIRTH (month, day, and year) *Feb-8-1922*  
7 AGE Years Months Days *0 0 7* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*(b) General nature of industry, business, or establishment in which employed (or employer) *none*(c) Name of employer *none*9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Maryland*10 NAME OF FATHER *John G. Buck*11 BIRTHPLACE OF FATHER (city or town) *Farm Royal* (State or country) *Virginia*12 MAIDEN NAME OF MOTHER *Nellie Perkins*13 BIRTHPLACE OF MOTHER (city or town) *unknown* (State or country) *Kansas*

## PARENTS

14 Informant (Address) *John G. Buck (father)*  
*St Paul Apts*

15 Filed

FEB 16 1922

ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/16/1922*17 I HEREBY CERTIFY, That I attended deceased from *2/8/1922* to *2/15/1922*that I last saw him alive on *2/15/1922*and that death occurred, on the date stated above, at *2 P.* m.

The CAUSE OF DEATH\* was as follows:

*Pat. - terminal disease*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *P. S. S. Lymph* M. D.(Signed) *J. J. Hervey*

, 19

(Address) *St Paul Apts*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Green Mount Cemetery* *Feb 16, 1922*

20 UNDERTAKER

*STEWART & MOWEN COMPANY*  
*WILLIAM F. WOODEN, Successor*

ADDRESS

*108 W. NORTH AVE.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

*Wm B Dignman*  
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61374

## CERTIFICATE OF DEATH.

X 31 D 61374

1-PLACE OF DEATH U.S. Veterans Hospital #56  
CITY OF BALTIMORE: (No. *24* Ft. McHenry, Baltimore, Md., WARD)

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Dignman, William B.* C-291742

(a) RESIDENCE NO. *Ft. McHenry Baltimore, Md. St.* WARD  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)  
*Male White Single*

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*26 - -*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Lineman*

(b) General nature of industry, business, or establishment in which employed (or employer) *--*

(c) Name of employer *--*

9 BIRTHPLACE (city or town) *Md.*  
(State or country)

10 NAME OF FATHER *Unknown*

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Unknown*

12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Unknown*

14 Informant *E.T. Rosenbrock*  
(Address) *Registrar*

15 Filed *19*  
*FEB 16 1922* *ROBERT R. KRAUTER,*  
Burial Permit Clerk, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/15/22* 19

17 I HEREBY CERTIFY, That I attended deceased from  
*12/27/21* 19 to *2/15/22* 19  
that I last saw him alive on *2/15/22* 19  
and that death occurred, on the date stated above, at *7:15 A.M.*  
The CAUSE OF DEATH\* was as follows:

*Diabetes Mellitus*

*Unknown* (duration) yrs. mos. ds.

CONTRIBUTORY *Tuberculosis chronic pulmonary*  
(Secondary) *Mod. adv. Active*  
(duration) yrs. mos. ds.

18 Where was disease contracted  
If not at place of death? *Unknown*

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Clinical*  
(Signed) *J. N. Gordon* M. D.  
*2/16/22* (Address) *Ft. McHenry, Md.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

*Bukeley Spring W. Va*

20 UNDERTAKER

*J. H. Hinson & Co.*

DATE OF BURIAL

*2/16, 1922*

ADDRESS

*E. Balt.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-  
TION is very important. See instructions on back of certificates.



**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Nonresident J Balto.*  
*Residence Berkeley*  
*Springs, W. Va.*

HEALTH DEPARTMENT CITY OF BALTIMORE

D 61375

CERTIFICATE OF DEATH.

90 D 61375

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1201 Morling ave ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virgil M. Gayce

(a) RESIDENCE. NO. 1201 Morling ave ST.

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of Charles D. Gayce (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 2 1895

7 AGE 26 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED Housewife

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Samuel Griffith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Josephine Stenmark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Charles D. Gayce (Address) 1201 Morling ave

15 FEB 10 1922 ROBERT H. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1922

17 I HEREBY CERTIFY, that I attended deceased from Feb 12 1922 to Feb 14 1922 and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH\* was as follows:

Galbladder disease of heart.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What was the cause of death? (Signed) J. M. D.

19 (Address) 3672 Roland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St Marys Hospital Feb 17 1922

20 UNDERTAKER ADDRESS

Chenoweth & Son Chestnut

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61376

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

604 W 34

ST. 13 WARD)

## 2-FULL NAME

Mary E Aldrich

(a) RESIDENCE NO.

604 W 34

ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

30

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Clifton J Aldrich

6 DATE OF BIRTH (month, day, and year)

Sep 28 1872

7 AGE

48

Years

Months

4

Days

17

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

M D

10 NAME OF FATHER

William Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country)

M D

12 MAIDEN NAME OF MOTHER

James Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

M D

14

Informant (Address)

Clifton J Aldrich 604 W 34 St

15

FEB 16 1922

ROBERT R. KRAUTER,

Registrar

20 UNDERTAKER

Chenoweth Son

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Lorraine Leem

DATE OF BURIAL

Feb 16 1922

ADDRESS

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 14 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov 1 1921, to Feb 14 1922

that I last saw her alive on

2/13

and that death occurred, on the date stated above, at

2:15 A.M.

The CAUSE OF DEATH\* was as follows:

carcinoma - uterus &amp; appendages

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Yes Date of Nov 14, 1921

Was there an autopsy? No.

What test confirmed diagnosis? Lab.

(Signed)

Growth of Hoff

M. D.

4/4, 1922

(Address) 2020 N. Charles

\*State the Disease, Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Lorraine Leem

DATE OF BURIAL

Feb 16 1922

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61377

## CERTIFICATE OF DEATH.

32 D 61377

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3018 O'Donnell St. ST. 1st WARD)

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

John Gerard Pohlhaus.  
3018 O'Donnell St. ST. 1st WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov. 11 - 1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7

3

4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

John M. Pohlhaus

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Md.

12 MAIDEN NAME OF MOTHER

Agnes Schuetz

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Md.

14

Informant (Address)

John M. Pohlhaus.  
3018 O'Donnell St.

15

Filed

FEB 16 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 15 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1922, to Feb. 15, 1922, that I last saw him alive on Feb. 15, 1922, and that death occurred, on the date stated above, at 9:45 a. m.

The CAUSE OF DEATH\* was as follows:

Tubercular Meningitis

(duration) yrs. mo. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mo. ds.

18 Where was disease contracted if not at place of death?

+

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Simular puncture

(Signed)

W. M. Avey M. D.

16, 1922 (Address) 839 S. Ellwood Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Holy Redeemer Cem.

DATE OF BURIAL

Feb 17 1922

20 UNDERTAKER

Lilly &amp; Zuber

ADDRESS

403 S. Wolfe St.



tion should be carefully supplied. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 1-10-21-M&T-1500 Rks.

61378

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 S. Robinson St. ST., 1 WARD)

2-FULL NAME

Lena O'taas.

(a) RESIDENCE NO. 709 S. Robinson St. ST., 1 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds.

How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George O'taas.

6 DATE OF BIRTH (month, day, and year) Oct 10 - 1866

7 AGE Years 55 Months 4 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed (or employer) at home.  
(c) Name of employer

9 BIRTHPLACE (city or town) Germany.  
(State or country)

10 NAME OF FATHER George Fuhrer.

11 BIRTHPLACE OF FATHER (city or town) Ger.  
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Schubert.

13 BIRTHPLACE OF MOTHER (city or town) Ger.  
(State or country)

14 Informant Carrie O'Brien.  
(Address) 709 S. Robinson St.

15 Filed 161378 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1922, to Feb. 14, 1922, that I last saw her alive on Feb. 14, 1922.

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary) Endocarditis  
(duration) yrs. mos. 17 ds.

(duration) yrs. mos. 5 ds.

18 Where was disease contracted at home  
if not at place of death?

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Physical signs  
(Signed) C. D. Fuhrer, M. D.

, 19 (Address) 408 D. Patterson Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mount Carmel Cem.

20 UNDERTAKER

Lilly & Zuber.

DATE OF BURIAL

Feb 17 1922

ADDRESS

403 S. Wolfe St.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

*K* *(Guenkel)*  
HEALTH DEPARTMENT—CITY OF BALTIMORE  
D 61379 1812 61379 1001

CERTIFICATE OF DEATH.

PLACE OF DEATH  
CITY OF BALTIMORE (NO. *20 n Myrdina-6*) WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME *John Guenkel*  
(Residence in Baltimore: No. *20 n Myrdina*) St.; *Life* mos. ds.)

REGISTERED No. C

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *Chs 8* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*  
(Write the word.)

6-DATE OF BIRTH, *Mar 20, 1873*  
(Month) (Day) (Year)

7-AGE, *48* yrs. *8* mos. *22* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *Huckster*  
(b) General nature of industry, business, or establishment in which employed (or employer). *045*

9-BIRTHPLACE, (State or Country), *Balto Md.*

PARENTS.

10-NAME OF FATHER, *Joseph Guenkel*

11-BIRTHPLACE OF FATHER (State or Country), *Balto. Md.*

12-MAIDEN NAME OF MOTHER, *Mary Ann*

13-BIRTHPLACE OF MOTHER (State or Country), *Balto Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) *Barbara Cook (Aunt)*  
(Address) *243 S. Castle St*

15- *GEY*  
Filed *FEB 16 1922* 191. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb 12, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said... (Inquest, au-  
topsy or inquiry.) find that said deceased came to... death  
on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
*Cerebral hemorrhage*  
*probably accidental*  
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...  
(Duration) ... yrs. ... mos. ... ds.  
(Signed) *John J. Guenkel* M. D.  
(Coroner)  
2-15-101... (Address) *15-101*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).  
At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.  
Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer Ch* DATE OF BURIAL, *Feb 16, 1922*

20-UNDERTAKER, *Lilly and Ziehl* ADDRESS, *403 S. Wolfe St*

N. B.—Every item of information given is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE  
CERTIFICATE OF DEATH.

D 61380  
PLACE OF DEATH

CITY OF BALTIMORE (No. 207 Myrdria St. 6 WARD)

2-FULL NAME Katherine Guentel

(Residence in Baltimore: No. 207 Myrdria

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH, Nov. 7, 1887. (Month) (Day) (Year)

7-AGE, 34 yrs. 3 mos. 5 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Housework (b) General nature of industry, business, or establishment in which employed (or employer). at home

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS. 10-NAME OF FATHER, John P. Michaels 11-BIRTHPLACE OF FATHER (State or Country), Balto Md. 12-MAIDEN NAME OF MOTHER, Sophia C. Walters 13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Sophia C. Michaels (Address) 2308 Cambridge St.

15- FEB 16 1922 191. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 12, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Asphyxia Illuvalis Gos, probably accidental. (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) (Signed) J. J. M. D. (Coroner) 191... (Address)...

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death...yrs. ...mos. ...ds. In the State...yrs. ...mos. ...ds. Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL, Baltimore Md. DATE OF BURIAL, Feb 16, 1922.

20-UNDERTAKER, Lily and Zeller ADDRESS, 403 S. Wolfe.

(Zinser) ✓  
D 61381 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 61381  
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2219 Madison Ave. ST. 13 WARD)

2-FULL NAME Mrs. Clementine Zinser

(Residence in Baltimore: No. 2219 Madison Ave.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

45 St., yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, W.

5-SINGLE, Married  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH, April 18, 1851

7-AGE, 70 yrs. 9 mos. 27 ds.

If LESS than 1 day,  
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...

Housework  
037

9-BIRTHPLACE, (State or Country),

Barania Germany

10-NAME OF FATHER, Jacob Neuberg

11-BIRTHPLACE OF FATHER (State or Country),

Barania Germany

12-MAIDEN NAME OF MOTHER, Clementine Neuberg

13-BIRTHPLACE OF MOTHER (State or Country),

Barania Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant, C. Zinser)

(Address, 2219 Madison Ave.)

15-

16-

17-

Registrar, J. H. H.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 14, 1922

(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry,

thereon and from the evidence obtained by said inquest, autopsy or inquiry,

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Heart Disease

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. H. H. M. D. (Coroner)

(Address) 7632 Rockwell Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, Feb 16, 1922

20-UNDERTAKER, David J. J.

ADDRESS, 118 N. Royal St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61382

## CERTIFICATE OF DEATH.

D 61382

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1105-6<sup>th</sup> St. Norrell Park ST. WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

## (a) RESIDENCE

No. 1105-6<sup>th</sup> St. Norrell Park ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Watt

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years 79 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md  
(State or country)10 NAME OF FATHER unknown11 BIRTHPLACE OF FATHER (city or town) unknown  
(State or country)12 MAIDEN NAME OF MOTHER unknown13 BIRTHPLACE OF MOTHER (city or town) unknown  
(State or country)

## 14

Informant Barnie Brown  
(Address) 1105 6<sup>th</sup> St. Norrell Park

## 15

FEB 16 1922

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 15, 1922

17

I HEREBY CERTIFY, that I attended deceased from

Jan 1 - 1922 February 15, 1922  
that I last saw her alive on February 14, 1922and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH\* was as follows:

Senility. Arterio Sclerosis.  
Chronic Nephritis  
(duration) unknown ds.CONTRIBUTORY  
(Secondary)Arterio Sclerosis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert H. Gatch M. D.2/15/22 (Address) 251 Madison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Western Cemetery Feb. 18<sup>th</sup> 1922

## 20 UNDERTAKER

## ADDRESS

John J. Childs 1200 W. Lombard St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61383

## CERTIFICATE OF DEATH.

D 61383

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1755 N Gay St. WARD) 8

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Samuel J. Barton

## (a) RESIDENCE. No.

1755 N GayST., 8 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

83 yrs. 8 mos. 26 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Widowed

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofAnna E. Barton

## 6 DATE OF BIRTH (month, day, and year)

May 20-1838

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

83826

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town, State or country)

Baltimore Md

## 10 NAME OF FATHER

Samuel S. Barton

## 11 BIRTHPLACE OF FATHER (city or town, State or country)

Baltimore Md

## 12 MAIDEN NAME OF MOTHER

Not Known

## 13 BIRTHPLACE OF MOTHER (city or town, State or country)

Unknown

## 14

Informant  
(Address)Samuel J. Barton  
1755 N. Gay St

## 15

FEB 16 1922

ROBERT H. KRAUTER

Bureau Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb 15 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb 14, 1922, to Feb 15, 1922that I last saw him alive on Feb 14, 1922and that death occurred, on the date stated above, at 12.15 A.M.

The CAUSE OF DEATH\* was as follows:

Chronic Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTOR  
(Secondary)Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoneWhat test confirmed diagnosis? None(Signed) J. P. Herzog, M.D. M. D.yrs. 1922 (Address) 1305 N. Patterson Pk

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Louden ParkFeb 17 1922

## 20 UNDERTAKER

Henry Lutz

## ADDRESS

1203 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D 61384

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. 512 Bonding Ave. ST. 11 WARD)

2-FULL NAME John W. Warfel

(a) RESIDENCE NO. 512 Bonding Ave. ST. 11 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. 10 mos. 23 ds.

(If nonresident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced  
HUSBAND of (or) WIFE of Grace L. Warfel

6 DATE OF BIRTH (month, day, and year) Mar. 28 1880

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Eben M. Warfel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Kate

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14

Informant (Address)

Grace L. Warfel  
512 Bonding Ave.

FEB 16 1922

ROBERT R. KNIGHTS  
Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 5, 1922, to Feb. 15, 1922, that I last saw him alive on Feb. 15, 1922, and that death occurred, on the date stated above, at 3 A. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

Pulmonary Hemorrhage

(duration) yrs. mos. ds. 10

18 Where was disease contracted  
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed)

Noel H. H. M. D.

2-15-1922 (Address) 5600 York Rd.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Parkwood Cem.

20 UNDERTAKER

Philip H. Hennig

DATE OF BURIAL

Feb. 17 1922

ADDRESS 2016

Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61385

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61385

## CERTIFICATE OF DEATH.

### PLACE OF DEATH

CITY OF BALTIMORE (No. *3909 Roland Ave* St. *9* WARD)

2-FULL NAME *Agnes B Burns*

(Residence in Baltimore: No. *520 E 27th St*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. *50* mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

1-SEX *Female*

4-COLOR OR RACE *White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*

6-DATE OF BIRTH *June 27, 1857*

(Month)

(Day)

(Year)

7-AGE *64*

yrs. mos. ds.

If LESS than 1 day, ....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Homework*  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country) *Richmond Va*

10-NAME OF FATHER *John Carney*

11-BIRTHPLACE OF FATHER (State or Country) *Ireland*

12-MAIDEN NAME OF MOTHER *Don't know*

13-BIRTHPLACE OF MOTHER (State or Country) *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A B Burns*

(Address) *520 E 27th St*

15-

Filed *FEB 16 1922*

191. ROBERT R. KRAUTER,

Burial Permit *1442*

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb 13th*, 19*22*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said *Inquiry* (Inquest, autopsy, or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Valvular disease of heart*  
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *John Morrison* M. D. (Coroner.)

*Feb 15 1922* (Address) *3632 Roland Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *New Cathedral*

DATE OF BURIAL, *Feb 17, 1922*

20-UNDERTAKER *Robt Turner*

ADDRESS *1442 Broadway*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61386

D 61386

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *318 Forest Road*)ST. *27* WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *318 Forest Road*)St.; yrs. *3* mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*6-DATE OF BIRTH, *Dec. 24, 1845*  
(Month) (Day) (Year)7-AGE, *77* yrs. *1* mos. *23* ds. If LESS than 1 day, ....hrs. or....min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *Retired*  
(b) General nature of industry, business, or establishment in which employed (or employer), *ooo*9-BIRTHPLACE, (State or Country), *Md.*10-NAME OF FATHER, *Philip Silver*11-BIRTHPLACE OF FATHER (State or Country), *Md.*12-MAIDEN NAME OF MOTHER *Alia Holman*13-BIRTHPLACE OF MOTHER (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. James H. Taylor*(Address) *318 Forest Road*

15- Robert P. Harrison, Registrar.

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *February 16, 1922*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 13, 1920* to *Feb. 16, 1922*, that I saw her alive on *February 15, 1922*, and that death occurred, on the date stated above, at *5.25 a.m.*

The CAUSE OF DEATH\* was as follows:

*Myocarditis*(Duration) *5* yrs. *10* mos. *10* ds.

CONTRIBUTORY (Secondary)

(Duration) *3* yrs. *10* mos. *10* ds.(Signed) *George M. R. R. R.* M. D.*Feb. 16, 1922* (Address) *2435 Maryland Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Hurlington Md.*19-PLACE OF BURIAL OR REMOVAL, *Hurlington Md.*20-UNDER-TAKER, *H. S. Bailey*DATE OF BURIAL, *Feb. 18, 1922*ADDRESS, *Hurlington Md.*

important. See instructions on back of certificate.

D 61387

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61387

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3118 Foster Ave

ST. 1

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Frederick W. Knoll

## (a) RESIDENCE. NO.

3118 Foster Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of

Emma C. Knoll

## 6 DATE OF BIRTH (month, day, and year)

Feb. 5-1873

## 7 AGE

49

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Craneman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. Copper + Smelting Co.

## 9 BIRTHPLACE (city or town) (State or country)

Balto., Md.

## 10 NAME OF FATHER

John Knoll

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Elizabeth Sommer

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

## 14 Informant (Address)

Emma C. Knoll  
3118 Foster Ave

## 15 Filed

Robert P. Harriech,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16 1922

17 I HEREBY CERTIFY, That I attended deceased from

8 Feb 1922, to 15 Feb 1922,

that I last saw him alive on 15 Feb 1922,

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

## CONTRIBUTORY (Secondary)

Same

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Surgeon + Spultum

19 (Address) 3015 Ellwood

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

Mt. Carmel

Feb 18 1922

Girler + Girler

Gager

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

16 1922

D 61388

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61388

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2823 Mosher St ST. 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 2823 Mosher St St.: 40 yrs., 0 mos., 0 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widowed6-DATE OF BIRTH, unknown 1838  
(Month) (Day) (Year)7-AGE, 84 yrs., 0 mos., 0 ds. If LESS than 1 day, ... hrs. or ... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), Italy10-NAME OF FATHER, Antonino Geppi11-BIRTHPLACE OF FATHER (State or Country), Italy12-MAIDEN NAME OF MOTHER Maddalena Caruagge13-BIRTHPLACE OF MOTHER (State or Country), Italy

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Vincent Geppi(Address) 2823 Mosher St

## 15-

Robert P. Harrison,

Filed 61922 191. Registrar.

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 15, 1922  
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from Feb. 13 1922, to Feb. 15 1922, that I saw him alive on Feb. 15 1922, and that death occurred, on the date stated above, at 8.9 m.

The CAUSE OF DEATH\* was as follows:

Polio  
(Duration) 2 yrs., 0 mos., 0 ds.

## CONTRIBUTORY (Secondary)

(Signed) Chs. Festa M. D.  
(Address) 210 Pearl St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs., 0 mos., 0 ds. In the State 0 yrs., 0 mos., 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

New Cathedral Cemetery Feb. 17, 1922

## 20-UNDERTAKER ADDRESS

George J. Ruth 1735 Harford Ave

important. See instructions on back of certificate.

D 61389

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61389

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 36 N. Lakewood ave ST. 6 WARD)

## 2-FULL NAME

Clara C. Dausch

## (a) RESIDENCE NO.

36 N. Lakewood ave ST. 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 18, 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

53

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Joseph S. Dausch

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Clara J. Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

Joseph S. Dausch  
36 N. Lakewood ave

15

6 1922

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 1, 1922 to Feb. 15, 1922that I last saw her alive on Feb. 14, 1922and that death occurred, on the date stated above, at 5:45 m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia(duration) yrs. mos. 15 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) E. S. Perrazzo M. D.2.15.22 19 (Address) 200 Hill St. - Baltimore

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Redeemer CanFeb 17 1922

20 UNDERTAKER

ADDRESS

Mrs C Miller2334 Jeffers



61390

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61390

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (NO. JOHNS HOPKINS HOSPITAL ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mildred Beveridge

## (a) RESIDENCE, NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 1 mos.

ds. How long in U. S., if of foreign birth?

(If nonresident give city or town and State)

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

March 9 - 1905

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

16116

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

000

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

W. Virginia

## 10 NAME OF FATHER

Wm. Beveridge

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pennsylvania

## 12 MAIDEN NAME OF MOTHER

Elmira Seidler

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

W. Virginia

## 14

Informant (Address)

JOHNS HOPKINS HOSPITAL

## 15

Filed

Robert P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb. 15 - 1922

## 17 I HEREBY CERTIFY, That I attended deceased from

Feb. 2 - 1922, to Feb. 15 - 1922that I last saw him alive on Feb. 15 - 1922and that death occurred, on the date stated above, at 9:00 P.M.

The CAUSE OF DEATH was as follows:

Brain tumor  
glioma cerebellum(duration) 3 yrs. 6 mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death?

YesDate of Feb. 8, 1922

Was there an autopsy?

Yes

What test confirmed diagnosis?

Operation + autopsy

(Signed)

Emile Holman, M. D.

2/16, 19

(Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Beth W. Va.Feb. 16 1922

## 20 UNDERTAKER

ADDRESS

Wm. L. Black 927 N. Broadway

8161922

Burial Permit Clerk?

D 61391

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61391

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 7 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Benjamin B. Christy

## (a) RESIDENCE. NO.

Fort Worth

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 1 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Jan. 7<sup>th</sup> 1895

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.1719

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Indiana

## 10 NAME OF FATHER

Andrew Christy11 BIRTHPLACE OF FATHER (city or town)  
(State or country)N. Carolina

## 12 MAIDEN NAME OF MOTHER

Isabella Martin13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)N. Carolina

## 14

Informant  
(Address)JOHNS HOPKINS HOSPITALRecords

## 15

Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb. 16<sup>th</sup> 1922

## 17

I HEREBY CERTIFY. That I attended deceased from

Jan. 2<sup>nd</sup> 1921, to Feb. 16<sup>th</sup> 1922that I last saw him alive on Feb. 16<sup>th</sup> 1922and that death occurred, on the date stated above, at 4 A. M.

The CAUSE OF DEATH\* was as follows:

Anemia (cause undetermined)(duration) 2 yrs.  mos.  ds.CONTRIBUTORY  
(Secondary)(duration)  yrs.  mos.  ds.18 Where was disease contracted  
if not at place of death?FloridaDid an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Blood exam.(Signed) E. Bowles Andrews, M. D.19 (Address) Johns Hopkins Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Hawthorne Fla.Feb. 17 1922

## 20 UNDERTAKER

Joseph Adams

## ADDRESS

221 W. Broadway

CAUSE OF DEATH IN plain terms, so that it may be understood by the jury. See instructions on back of certificates. TION is very important.

B 16 1922

Burial Permit Clerk:

D 61392

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61392

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No.

1802 E Eager

ST.

WARD

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

William H Spencer

(Residence in Baltimore: No.

1802 E Eager

St.: yrs. 16 mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male  
4-COLOR OR RACE, White  
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single  
(Write the word.)

## 6-DATE OF BIRTH,

June 15, 1871  
(Month) (Day) (Year)

## 7-AGE,

50 yrs. mos. ds.  
If LESS than 1 day, hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).Steam fitter  
0609-BIRTHPLACE,  
(State or Country),

Worcester Mass

## 10-NAME OF FATHER,

Wm H Spencer

11-BIRTHPLACE OF FATHER  
(State or Country),

Springfield Mass

## 12-MAIDEN NAME OF MOTHER

Minnie E Dunn

13-BIRTHPLACE OF MOTHER  
(State or Country),

Shrewsbury Mass

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Fred H Spencer  
Clarendon Va 313 Back St

(Address)

## 15-

Filed 84022

Robert F Harrison,

191

Burial Permit Clerk. Registrar.

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Feb 10, 1921  
(Month) (Day) (Year)

## 17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Suicide by Illuminating

Gas  
(Duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)(Duration) yrs. mos. ds.  
(Signed) M. D.

12-16-21 (Address) 313 Back St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the  
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

## Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Worcester Mass.

## DATE OF BURIAL,

Feb 17, 1921

## 20-UNDERTAKER

John F. Denny

## ADDRESS

715 Light St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61393

D 61393

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *South Balto. Gen. Hospital* ST. *24* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Mrs. Belle Netre*

## (a) RESIDENCE, NO.

*121 E Randall*

ST.

WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Widow*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*William A Netre*6 DATE OF BIRTH (month, day, and year) *Aug 20 1850*7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*71* *5* *25*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*House - work*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Cumberland Md*

## 10 NAME OF FATHER

*James A Ferguson*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balto Md*

## 12 MAIDEN NAME OF MOTHER

*Rose Peterman*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Maryland*

## 14

Informant (Address)

*James G. Ferguson*  
*121 E Randall*

## 15

Filed

*Robert F. Harrison*

19

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 14* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *Feb 12*, 19 *22*, to *Feb 14*, 19 *22*, that I last saw him alive on *Feb 14*, 19 *22*, and that death occurred, on the date stated above, at *6:15 P.m.*  
The CAUSE OF DEATH\* was as follows:  
*Left foot. Spontaneous gangrene of*

## CONTRIBUTORY (Secondary)

(duration) yrs. *2* mos. ds.*Acute uraemia*

18 Where was disease contracted if not at place of death?

*at home*Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *none*

(Signed)

, 19 (Address)

*Joseph Pokorny, M. D.*  
*South Balto Gen. Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Cedar Hill*

## DATE OF BURIAL

*Feb 17 1922*

## 20 UNDERTAKER

*John H. Denny*

ADDRESS

*715 Light*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Cause of Death is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61394

D 61394

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1612 N. Fulton Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1612 N. Fulton Ave St.: 30 yrs., 11 mos., 29 da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single  
(Write the word.)

6-DATE OF BIRTH. February 17, 1891.  
(Month) (Day) (Year)

7-AGE. 30 yrs., 11 mos., 29 da. If LESS than 1 day, ....hrs. or ....min.

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. Salesman  
(b) General nature of industry, business, or establishment in which employed (or employer). Tea & Coffee Business

9-BIRTHPLACE, (State or Country). Baltimore, Md.

10-NAME OF FATHER. H. P. Schultz

11-BIRTHPLACE OF FATHER (State or Country). Barroll Co., Md.

12-MAIDEN NAME OF MOTHER. Senora M. Burns

13-BIRTHPLACE OF MOTHER (State or Country). Barroll Co., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. P. Schultz

(Address) 1612 N. Fulton Ave.

15-

Robert P. Harrison,

B 16 1922 Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb 16, 1922.  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Jan 30, 1922, to Feb 16, 1922, that I saw him alive on Feb 15, 1922, and that death occurred, on the date stated above, at 7<sup>15</sup> a. m.

The CAUSE OF DEATH\* was as follows:

Typhoid Fever  
(Duration) 7 yrs., 1 mo., 21 da.

CONTRIBUTORY (Secondary) Chronic Nephritis  
(Duration) 1 yrs., 1 mo., 1 da.

(Signed) O. H. Duval M. D.  
Feb 16, 1922 (Address) 1817 N. Fulton Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. .... yrs. .... mos. .... ds. In the State. .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Western Cemetery DATE OF BURIAL. Feb 18, 1922

20-UNDERTAKER. Elmer W. Franklin ADDRESS 924 E. Eager St.

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 61395

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61395

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (Not *21 N. Washington St.* WARD) *6*

2-FULL NAME *Oscar Weiss*

(a) RESIDENCE NO. *21 N. Washington St.* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *14* yrs. mos. ds.

How long in U. S., if of foreign birth? *14* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed or divorced HUSBAND of (or) WIFE of *Annie Weiss*

6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *72 — —*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Russia*

10 NAME OF FATHER *Morris Weiss*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Russia*

12 MAIDEN NAME OF MOTHER *Eldy*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Russia*

14 Informant *Abraham Weiss* (Address) *2618 E. Baltimore*

15 *FEB 17 1922* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 16 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Feb. 13*, 1922, to *Feb. 16*, 1922.

that I last saw him alive on *Feb. 16*, 1922, and that death occurred, on the date stated above, at *8:30 P. m.*

The CAUSE OF DEATH\* was as follows:

*Bronchopneumonia (myocarditis of old age)*

(duration) yrs. mos. ds. *8*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *8*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Frank J. Smith*, M. D.

*Feb. 17, 1922* (Address) *927 E. Calvert St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Heaven Mt. Carmel*

*2/17 1922*

20 UNDERTAKER

ADDRESS

*Jack Lewis 1417 E. Baltimore*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61396

D 61396

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2906 Huntingdon Ave. 17

ST.: WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Francis Neal Peck

## (a) RESIDENCE. NO. 2906 Huntingdon Ave. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 4 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Sept 24 - 1919

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

4

24

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore City

## 10 NAME OF FATHER

Charles E. Petett

## 11 BIRTHPLACE OF FATHER (city or town)

Maryland

## 12 MAIDEN NAME OF MOTHER

Eva, G. William

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore City

## 14

Informant (Address)

Charles E. Petett 2906 Huntingdon Ave

## 15

FEB 17 1922

ROBERT R. KRAUTER

Bureau Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb. 15 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

May 1 1921, to Feb 15 1922.

that I last saw him alive on Feb 15 1922.

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH\* was as follows:

Secondary Anemia (Prolonged gastric ulcer)

(duration) yrs. 10 mos. ds.

## CONTRIBUTORY (Secondary)

Glandular Fever

(duration) yrs. 8 mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? History &amp; Physical signs

(Signed) R. B. Norman M. D.

217, 1922 (Address) 3547 Chestnut Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Druid Ridge Feb 17 22

## 20 UNDERTAKER

A. S. Marshall 3539 Fall Rd

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No further history*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61397

## CERTIFICATE OF DEATH

57 D 61397

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1301 E Lombard St. 3 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1301 E Lombard St. yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 4-COLOR OR RACE, 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, 7-AGE, If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country).

PARENTS. 10-NAME OF FATHER, 11-BIRTHPLACE OF FATHER, (State or Country), 12-MAIDEN NAME OF MOTHER, 13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

FEB 17 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 17- I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said... (Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above. The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) M. D. (Coroner) (Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

20-UNDERTAKER, ADDRESS

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH

D 61398

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *Balto City Jail* ST. *60* WARD)

2-FULL NAME *Elemer Hoffman*

(Residence in Baltimore: No. *218 N. Bradford* St. *unknown* yrs. *unknown* mos. *unknown* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *col* 5-SINGLE, *Single*  
*WIDOWED*  
*OR DIVORCED*  
(Write the word)

6-DATE OF BIRTH *unknown, 1*  
(Month) (Day) (Year)

7-AGE *24* yrs. *-* mos. *-* ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION  
(a) Trade, profession, or particular kind of work *unknown*  
(b) General nature of industry, business, or establishment in which employed (or employer) *087*

9 BIRTHPLACE (State or country) *unknown*

10 NAME OF FATHER *unknown*

11 BIRTHPLACE OF FATHER (State or country) *unknown*

12 MAIDEN NAME OF MOTHER *unknown*

13 BIRTHPLACE OF MOTHER (State or country) *unknown*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *John J. Ayd*

(Address) *Loyola College*

15 *FEB 17 1922* *ROBERT R. KRAUTER*  
Burial Permit Clerk, REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Feb 17, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Feb 17, 1922* to *Feb 17, 1922* that I saw him alive on *Feb 17, 1922* and that death occurred, on the date stated above, at *8:15* m. The CAUSE OF DEATH\* was as follows:  
*Hanging by neck*

(Duration) .... yrs. .... mos. .... ds.  
Contributory *Dislocation Cervical*  
(SECONDARY) *Dislocation*  
(Signed) *A. J. Gower* M. D.  
*2/17/1922* (Address) *921 N. Charles*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .... yrs. .... mos. .... ds. In the  
Where was disease contracted, .... yrs. .... mos. .... ds.  
If not at place of death?  
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Secord Street Cemetery* DATE OF BURIAL *2/17, 1922*

20-UNDERTAKER *Mr. Mrs. N. J. Fink* ADDRESS *1835 W. Pratt*

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61399

D 61399

## CERTIFICATE OF DEATH.

### PLACE OF DEATH

CITY OF BALTIMORE (No. 913 St. Barnabas Court ST. 17 WARD)

### FULL NAME

(Residence in Baltimore: No. 913 St. Barnabas Court St. yrs. mos. da.)

### REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX female 4-COLOR OR RACE colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single  
6-DATE OF BIRTH, unknown, 1884 (Month) (Day) (Year)  
7-AGE, 38 yrs. mos. da. If LESS than 1 day, ... hrs. or ... min.?  
8-OCCUPATION: (a) Trade, profession, or particular kind of work... Laundress (b) General nature of industry, business, or establishment in which employed (or employer) 041

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.  
10-NAME OF FATHER, unknown  
11-BIRTHPLACE OF FATHER (State or Country), unknown  
12-MAIDEN NAME OF MOTHER, unknown  
13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) Daniel Earle  
(Address) 916 Be...

15- FEB 17 1922 191 REGISTRAR

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 13, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.  
The CAUSE OF DEATH\* was as follows:

Acute alcoholism  
(Duration) 1 yrs. 1 mos. 1 da.

CONTRIBUTORY (Secondary) (Duration) 1 yrs. 1 mos. 1 da.

(Signed) J. E. Harrison M. D. (Coroner.)

Feb. 17, 1922 (Address) 2802 Edmondson Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. da. In the State... yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, 2nd Union Ave DATE OF BURIAL, Feb. 18 1922

20-UNDERTAKER, Daniel Earle ADDRESS 218

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 4-9-10—H. P. Co.—1000 Bks.

D 61400

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61400

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

INLOES

CITY OF BALTIMORE: (No. 213 Inloes Alley

ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Freeman

(a) RESIDENCE. NO. 213 INLOES AL

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem 4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Freeman

6 DATE OF BIRTH (month, day, and year) Aug 24 1888

7 AGE Years Months Days 38 — 5 22 LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St Mary Co Md (State or country)

10 NAME OF FATHER Robt Dyson

11 BIRTHPLACE OF FATHER (city or town) St Mary Co Md (State or country)

12 MAIDEN NAME OF MOTHER Alice Brown

13 BIRTHPLACE OF MOTHER (city or town) Howardtown Md (State or country)

14 Informant Blancher Freeman (Address) 213 INLOES AL

15 Filed FEB 17 1922 ROBERT H. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/15 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1922, to Feb 14, 1922, that I last saw her alive on Feb 14, 1922, and that death occurred, on the date stated above, at 2 a. m. The CAUSE OF DEATH\* was as follows:

Strangulation Intestine

(duration) yrs. — mos. 3 ds.

CONTRIBUTORY Shock

(duration) yrs. — mos. — ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Gustav Goldman M. D.

19 (Address) 656 Dr Franklin

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

our funeral home

Feb 18 1922

20 UNDERTAKER

ADDRESS

Daniel Epton

87 E



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61401

D 61401

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 Myrtle av

ST. 17

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Emma Wilson Weston

## (a) RESIDENCE. NO.

502 Myrtle av

ST.

WARD.

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 6 mos.

ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Fem

## 4 COLOR OR RACE

W

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Robert Weston

## 6 DATE OF BIRTH (month, day, and year)

Aug 1882

## 7 AGE

39 — 6

If LESS than 1 day. hrs. or min.

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Household work

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

## 10 NAME OF FATHER

Wilson

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

unknown

## 12 MAIDEN NAME OF MOTHER

Martha Bowman

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Frederick Md

## 14

Informant (Address)

Robert Weston 502 Myrtle av

## 15

Filed

FEB 17 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb 15 1922

I HEREBY CERTIFY, That I attended deceased from Feb 5, 1922, to Feb 15, 1922, that I last saw her alive on Feb 14, 1922, and that death occurred, on the date stated above, at 9:05 P. M.

The CAUSE OF DEATH\* was as follows:

apoplexy

(duration) yrs. mos. 10 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted? If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Gustav Goldman M. D.

19 (Address) 1056 W. Frank Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

St. Peter's B.

Feb 20 1922

## 20 UNDERTAKER

Daniel E. Gorman

ADDRESS 946

Exact statement of OCCUPATION, CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 61402

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61402

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1034 G. Castle St. ST.: 7 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Llewellyn Moore

## (a) RESIDENCE. NO.

1034 G. Castle St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Infant

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Lynno

## 6 DATE OF BIRTH (month, day, and year)

Feb 9 / 22

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

6

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Balt

## 10 NAME OF FATHER

Llewellyn Moore

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt

## 12 MAIDEN NAME OF MOTHER

Anita Clement

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt

## 14

Informant (Address)

Llewellyn Moore  
1034 G. Castle St.

## 15

FEB 17 1922

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 9 1922 to Feb 15 1922that I last saw him alive on Feb 15 1922and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH\* was as follows:

Premature Birth

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Unknown

Did an operation precede death?

No

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Feb 16 1922

(Address)

77 Rutledge Pk  
100 North St

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Trinity CemeteryFeb 17 1922

## 20 UNDERTAKER

## ADDRESS

Max E. Evers1906 S. Park

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT - CITY OF BALTIMORE

D 61403

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 Ringold ST. 21 WARD)

## 2. FULL NAME

George Myrion Rasin

## (a) RESIDENCE NO.

303 Ringold ST. 21 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 12 1922 7 AGE Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant (Address)

## 15

FEB 17 1922

ROBERT R. KRAUTER

## 20 UNDERTAKER

Commissioner Health,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 192217 I HEREBY CERTIFY, That I attended deceased from Feb. 12 1922 to Feb. 12 1922, that I last saw him alive on Feb. 12 1922, and that death occurred, on the date stated above, at 5:30 A. M.

The CAUSE OF DEATH\* was as follows:

Unilateral HemorrhageCONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Capture of heart

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Examination(Signed) M. D. R. R. R. M. D.19 (Address) University Hospital

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

ADDRESS

UNIVERSITY OF MARYLAND

FEB 17 1922

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 61404

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *616 Pitcher*ST. *14* WARD)2-FULL NAME *Baby West.*(a) RESIDENCE NO. *616 Pitcher*  
(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Caucasian* 5 Single, Married, Widowed, or Divorced, (write the word) *Infant.*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb. 9-1922*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *3 1/2*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country) *Maryland*10 NAME OF FATHER *Thomas Smith*11 BIRTHPLACE OF FATHER (city or town) *Baltimore*  
(State or country) *Maryland*12 MAIDEN NAME OF MOTHER *Genevieve West*13 BIRTHPLACE OF MOTHER (city or town) *Pa.*  
(State or country)14 Informant  
(Address)15 *FEB 17 1922*  
FiledROBERT A. KRAUTER,  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 13 1922*17 I HEREBY CERTIFY, That I attended deceased from *Feb. 9*, 1922, to *Feb. 13*, 1922, that I last saw him *dead* on *Feb. 13*, 1922, and that death occurred, on the date stated above, at *9 a.m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Compression*

(duration) yrs. mos. ds.

CONTRIBUTORY *Prolonged Tumor*  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Examination*(Signed) *L. J. Rigby*, M. D., 19 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Commissioner Health,

*FEB 10 1922*

Wm. E. WOODBALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61405

D 61405

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1813 E. Lafayette Ave* ST. *8* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Infant Houch*(a) RESIDENCE. NO. *1813 E. Lafayette Ave* ST. *8* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*4 COLOR OR RACE *W*5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb 16, 1922*

7 AGE

Years

Months

Days

If LESS than 1 day, *4* hrs. or *—* min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Md*10 NAME OF FATHER *Elmer Houch*11 BIRTHPLACE OF FATHER (city or town) *Balto.* (State or country)12 MAIDEN NAME OF MOTHER *Frances H. Houch*13 BIRTHPLACE OF MOTHER (city or town) *Balto* (State or country)

14

Informant (Address)

15

Filed

FEB 17 1922

ROBERT R. KRAUTER  
Registrar  
Burial Permit Clerk,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 16* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 16*, 19*22*, to *Feb 16*, 19*22*.that I last saw him alive on *Feb 16*, 19*22*.and that death occurred, on the date stated above, at *8 A.* m.

The CAUSE OF DEATH\* was as follows:

*Prematurity*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *—* Date ofWas there an autopsy? *—*

What test confirmed diagnosis?

(Signed) *Louis A. M. Houch* M. D., 19 (Address) *3500 E. Madison St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHN HOPKINS HOSPITAL

20 UNDERTAKER

G. W. Houch

ADDRESS

FEB 16 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61406

## CERTIFICATE OF DEATH.

D 61406

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 S. Fulton Ave ST. 19 WARD)

## 2-FULL NAME Catherine J. O'Meara

(a) RESIDENCE. No. 125 S. Fulton Ave ST. 19 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds.

yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Catherine J. O'Meara

6 DATE OF BIRTH (month, day, and year)

May 16<sup>th</sup> 1839

7 AGE

82

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired 1073

(b) General nature of industry, business, or establishment in which employed (or employer)

Newark

(c) Name of employer

B &amp; O. R.R.

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

James O'Meara

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary Bartley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Mr. James O'Meara 1503 W. Lombard St.

15

FEB 17 1922

ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

February 16, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 4, 1922, to Feb 16, 1922,

that I last saw him alive on February 15, 1922,

and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

No

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Physical

(Signed) Edw. J. Coolsen, M. D.

1/17, 1922 (Address) 24 N. Fulton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cem

Feb 18, 1922

20 UNDERTAKER

ADDRESS

John J. Gowan &amp; Son 401 N. Holliday St.

401 N. Holliday St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 61407

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61407

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *9416 Chapel* St. Ward)

Registered No. C.....

## 2-FULL NAME

(Residence in Baltimore: No. *9416 Chapel* St.; yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *Colored* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Single*6-DATE OF BIRTH, *Aug 29* (Month) (Day) (Year) *1922*7-AGE, *6* yrs., mos., ds. If LESS than 1 day, hrs. or min.8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Baby* (b) General nature of industry, business, or establishment in which employed (or employer), *Baby*9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *John Hockady*11-BIRTHPLACE OF FATHER, (State or Country), *D. C.*12-MAIDEN NAME OF MOTHER, *Bethie O Neal*13-BIRTHPLACE OF MOTHER, (State or Country), *D. C.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Bethie Hockady*(Address) *9416 Chapel St.*15-*FEB 17 1922* ROBERT R. KRAUTER, Burial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb 17 1922* (Month) (Day) (Year)

17-I HEREBY CERTIFY That I took charge of the remains described above, held an inquest, autopsy or inquiry.

Thereon and from the evidence obtained by said inquest, autopsy or inquiry, I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Intestinal Rickets* (Duration) yrs., mos., ds. *Malnutrition*CONTRIBUTORY (Secondary) *Malnutrition* (Duration) yrs., mos., ds.(Signed) *J. T. O'Leary* M. D. (Coroner.)192 (Address) *1725 Ashland Ave*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*Laural Cemetery* *Feb 17 1922*20-UNDERTAKER, ADDRESS *1725 Ashland Ave**Mrs Robert A Elliott*

State CAUSE OF DEATH in plain terms, so that it may be easily understood. See instructions on back of certificate.

# Gastro Enteritis.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*,

*peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

*Abortion*, *Hemorrhage*, *Meningitis*, *Phlebitis*,  
*Cellulitis*, *Gangrene*, *Miscarriage*, *Pyemia*,  
*Childbirth*, *Gastritis*, *Necrosis*, *Septicemia*,  
*Convulsions*, *Erysipelas*, *Peritonitis*, *Tetanus*.

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.





# Homicide.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*,

*peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

*Abortion*, *Hæmorrhage*, *Meningitis*, *Phlebitis*,  
*Cellulitis*, *Gangrene*, *Miscarriage*, *Pyæmia*,  
*Childbirth*, *Gastritis*, *Necrosis*, *Septicæmia*,  
*Convulsions*, *Erysipelas*, *Peritonitis*, *Tetanus*.

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved): *Suicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61409

D 61409

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 N. Milton ave. WARD 7)

## 2. FULL NAME

(a) RESIDENCE NO. 902 N. Milton ave. WARD 7

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female4 COLOR OR RACE W5 Single, Married, Widowed, or Divorced, (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 3 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt10 NAME OF FATHER Herman Rebert11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt12 MAIDEN NAME OF MOTHER Barbara Holbrook13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14

Informant (Address) Herman Rebert

15

Filed

FEB 15 1922

J. H. Wehm

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1922

17

HEREBY CERTIFY, That I attended deceased from Feb 9 1922 to Feb 15 1922 that I last saw her alive on Feb 15 1922 and that death occurred, on the date stated above, at 12:00 p.m.

The CAUSE OF DEATH\* was as follows:

Brands - PneumoniaCONTRIBUTORY (Secondary) acute Cardiac Dilatation (duration) yrs. mos. 6 ds.18 Where was disease contracted if not at place of death? unknownDid an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? findings(Signed) Wm. J. R. 2-18-22 M. D.(Address) 800 N. Pratt St. Baltimore

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL

2-17 1922

20 UNDERTAKER

ADDRESS

Winifred Riffel & Son North Harbor

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

state CAUSE OF DEATH in plain terms, so that it may be properly translated. Exact translation is very important. See instructions on back of certificate.

D 61410

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61410

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: No. 1522 E. Balto. St. 6 Ward

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1522 E. Baltimore St.; yrs. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-Single, Married, Widowed, or Divorced, (Write the word)

Married

6-DATE OF BIRTH

Unknown (Month) (Day) (Year)

7-AGE

65 years (True) 707 yrs. mos. ds.

If LESS than 1 day

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

laborer OHG

9-BIRTHPLACE

(State or Country)

Russia

10-NAME OF FATHER

Herch Baumohl

11-BIRTHPLACE OF FATHER

(State or Country)

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Herch Baumohl

(Address)

1522 E. Balto St.

15-

Filed

1922

ROBERT R. KRAUTER

Burial Permit Clerk

FEB 17 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Feb 6 22 (Month) (Day) (Year)

17

I HEREBY CERTIFY that I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Sclerosis

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address) 1922

\*State the Illness Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL

Heintzel Cemetery

DATE OF BURIAL

Feb 17, 1922

20-IDENTIFIER

W. J. Or

ADDRESS

1127 E. Balto St.



State of Maryland, Baltimore City

to wit:

Be It Remembered, That on this 23<sup>rd</sup> day of February

A. D. 1922, before me, the subscriber, a Justice of the Peace of the said State in and for the

Martin M. Baumohl residing at  
 2326 McCulloch at Baltimore Md

aforesaid, personally appeared

and made oath in due form of law that he is the son of the

late Bernard Baumohl who died  
 on the 16<sup>th</sup> day of February 1922

that his age at death was  
 65 years - not 74 years as recorded  
 the health Department at Baltimore

affiants signature

Martin M Baumohl

Jacob Rab  
 Justice of the Peace.

D 61411

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61411

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

901 Full

ST.:

2

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Fannie Rosenberg

## (a) RESIDENCE. NO.

901 Full St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female White

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced (write the word)

married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Unknown

## 7 AGE

Years

Months

Days

If LESS than 1 day, — hra. or — min.

70

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Russia

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

## 14

Informant (Address)

Meyer Rosenberg 901 Full St.

## 15

Filed

19

ROBERT R. KRAUTER

Registrar

FEB 17 1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) Feb 17 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan 7 3rd 1922, to Feb 16 14 1922

that I last saw her alive on Feb 16 14 1922

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH\* was as follows:

Chronic interstitial nephritis &amp; hypertension

## CONTRIBUTORY (Secondary)

(duration) 3 yrs. mon. ds.

Dilated Heart

(duration) yrs. mon. ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. Chedever M. D.

2/7, 1922 Address) 375 Madison St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Hebrew Rosedale

Feb 17 1922

## 20 UNDERTAKER

## ADDRESS

Max Linsor

117 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61412

## CERTIFICATE OF DEATH.

REGISTERED NO. 99-000 61412

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 Archer St. 21 WARD)

2-FULL NAME Henry Glascoe.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 621 Archer ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

male Colored Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Malinda Glascoe

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 57

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond Co Va (State or country)

10 NAME OF FATHER Ned Glascoe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Co Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Homozella Davis (Address) 621 Archer St

15 FEB 17 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-16-1922

17 I HEREBY CERTIFY, That I attended deceased from 2-12-1922, to 2-16-1922,

that I last saw him alive on 2-16-22, 19

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH\* was as follows:

Senile Bronchitis (non tubercular.)

(duration) yrs. mos. ds.

CONTRIBUTORY Old Age (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clifford D. Miller, M. D.

, 19 (Address) 1727 Calverton

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Auburn Ct Feb 18 1922

20 UNDERTAKER ADDRESS

J. H. Brown &amp; Son 108 W. Myrtle

Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

61413

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15

181

001

D 61413

PLACE OF DEATH

CITY OF BALTIMORE (No. *2424 Leona, Cap. St.*) WARD

2-FULL NAME  
*J. Harry Allen*

(Residence in Baltimore: No. *N.Y. City (Suit 500 Astor Theatre Building)* St. yrs. mos. / ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male*

4-COLOR OR RACE, *white*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *married*  
(Write the word.)

6-DATE OF BIRTH, *about*  
*Unknown*, 18*62*  
(Month) (Day) (Year)

7-AGE, *about*  
*60* yrs. mos. ds. IF LESS than 1 day, hrs. or min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work *Bookkeeping agent*  
(b) General nature of industry, business, or establishment in which employed (or employer) *(Theatrical)*

9-BIRTHPLACE, (State or Country), *England*

PARENTS.

10-NAME OF FATHER, *Unknown*

11-BIRTHPLACE OF FATHER (State or Country), *Unknown*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) *Mr. Harry Baudell*  
(Address) *500 Cap. Theatre Bldg., (N.Y. City)*

15-*FEB 17 1922*

ROBERT R. KRAUTER,  
Burial Permit *191*

16-DATE OF DEATH, *February 17, 1922*  
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
*Asphyxiation by gas from gas heater*  
(Duration) yrs. mos. ds. *1 ds.*  
CONTRIBUTORY *accidental* (Secondary)  
(Duration) yrs. mos. ds. *1 ds.*  
(Signed) *J. T. Hennessy* M. D. (Coroner.)  
*Feb. 17, 1922* (Address) *2507 Edmondson Ave.*  
\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).  
At place *2424 Leona St.* in the of death yrs. mos. ds. State yrs. mos. ds.  
Where was disease contracted, if not at place of death? *500 Cap. Theatre Bldg., (N.Y. City)*  
Former or usual residence *500 Cap. Theatre Bldg., (N.Y. City)*  
19-PLACE OF BURIAL OR REMOVAL, *New York* DATE OF BURIAL, *Feb 17, 1922*  
20-UNDERTAKER, *Isaac Seyer* ADDRESS *1600 W North Ave*



N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 170 D 61414)

2-FULL NAME

(Residence in Baltimore: No. 206 S 8th St.)

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 8th, mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6-DATE OF BIRTH

Feb. 15, 1888 (Month) (Day) (Year)

7-AGE

34 yrs. 0 mos. 0 ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Latimer 940

9-BIRTHPLACE (State or Country).

Russia

10-NAME OF FATHER

Prokop. Grynko

11-BIRTHPLACE OF FATHER (State or Country).

Russia

12-MAIDEN NAME OF MOTHER

Caryna Lojko

13-BIRTHPLACE OF MOTHER (State or Country).

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Mary Grynko  
206 S. 8th St.

15

FEB 17 1922

Filed

191

ROBERT R. KRAUTER,

Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Feb. 16, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Suicide by gunshot  
Shot  
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D. (Coroner)

2-7-2, 191? (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

1 St. Evangelica 2/18/22

20-UNDERTAKER

ADDRESS

William Galkowsky 1618 Eastern Ave

D 61415

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61415

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 Hanover ST.: 73 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W. Demme(a) RESIDENCE. No. 1618 Hanover ST. WARD.  
(Usual place of abode)  
Length of residence in city or town where death occurred 55 yrs. 29 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced  
HUSBAND of Lillie B. Demme  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Jan 16 18677 AGE Years 55 Months 0 Days 29 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Metal Worker(b) General nature of industry, business, or establishment in which employed (or employer) O. S. B.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore10 NAME OF FATHER George B. Demme11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Mathias Pabst13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany14 Informant Lillie B. Demme  
(Address) 1618 Hanover15 Robert P. Harrison,  
Registrar

FEB 17 1922

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 192217 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Feb 15, 1922.that I last saw him alive on Feb 15, 1922, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of R.  
Bronchial Cleft(duration) yrs. mos. ds.  
CONTRIBUTORY Internal Hemorrhage  
(Secondary) (duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? not knownDid an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) G. H. Harrison M. D.  
Feb 16, 1922 (Address) 1618 Hanover

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park Cemetery Feb 17 192220 UNDERTAKER ADDRESS 1039Shelton & Son

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Origin in bronchial  
cleft. Internal  
hemorrhage.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61416

## CERTIFICATE OF DEATH.

D 61416

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1933 Walbrook St.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1933 Walbrook St.; 68 yrs., 6 mos., 20 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widowed  
(Write the word.)6-DATE OF BIRTH, July 26, 1840  
(Month) (Day) (Year)7-AGE, 81 yrs., 6 mos., 20 ds. If LESS than 1 day, ....hrs. or....min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. Box Letter  
(b) General nature of industry, business, or establishment in which employed (or employer). Retired9-BIRTHPLACE, (State or Country), Germany10-NAME OF FATHER, Unknown11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER Unknown13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert H. Harrison(Address) 1933 Walbrook

15-

Filed Robert H. Harrison Registrar.

7 1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 16, 1922  
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from Jan 1 1922, to Feb 16 1922, that I saw him alive on Feb 10 1922, and that death occurred, on the date stated above, at 8:45 m.

The CAUSE OF DEATH\* was as follows:

myocarditis(Duration) 3 yrs., 9 mos., 20 ds.CONTRIBUTORY myocarditis  
(Secondary)(Duration) 3 yrs., 9 mos., 20 ds.(Signed) Robert H. Harrison M.D.Feb 16, 1922 (Address) 101 N. Cal

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 3 yrs., 9 mos., 20 ds. In the State 3 yrs., 9 mos., 20 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park CemeteryDATE OF BURIAL, Feb 17, 192220-UNDERTAKER Edith M. HarrisonADDRESS 1039



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61417

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Charles St. Lakeland, 75th* ST. WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *Charles St. Lakeland* St.; *18* yrs., mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*male*

## 4-COLOR OR RACE.

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *married*

## 6-DATE OF BIRTH,

*Nov 30*, *1867*  
(Month) (Day) (Year)

## 7-AGE,

*54* yrs., *2* mos., *16* ds. If LESS than 1 day, ... hrs. or ... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Clerk*(b) General nature of industry, business, or establishment in which employed (or employer). *B & O R.R.*

## 9-BIRTHPLACE,

(State or Country) *Friendship U.C.*

## PARENTS.

## 10-NAME OF FATHER,

*William R. Cable*

## 11-BIRTHPLACE OF FATHER (State or Country),

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER (State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Eva. C. Cable*(Address) *Charles St. Lakeland*

## 15-

Filed *Robert F. Harrison,*

191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Feb*, *15*, *1922*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Feb 4*, *1922*, to *Feb 15*, *1922*that I saw him live on *Feb 15*, *1922*and that death occurred, on the date stated above, at *11:25 P.m.*

The CAUSE OF DEATH\* was as follows:

*Apoplexy*(Duration) *12* hrs., *30* min.CONTRIBUTORY (Secondary) *Arterio Sclerosis*(Duration) *?* yrs., *?* mos., *?* ds.(Signed) *Thasmece Wheeler, M. D.**Feb 15*, *1922* (Address) *Lakeland Ave.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, *?* yrs., *?* mos., *?* ds. In the State, *?* yrs., *?* mos., *?* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*London Park Cem.*

## DATE OF BURIAL,

*Feb. 18*, *1922*

## 20-UNDERTAKER

*Mrs. John R. Tupper & Son*

## ADDRESS

*801 N. Fayette*

important. See instructions on back of certificate.

17 1922 Partial Permit Clerk.

D 61418 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61418

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE (No. 2717 Harbor St. 16 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

(a) RESIDENCE NO. 2717 Harbor St. WARD

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, Divorced, (write the word)

6a If married, widowed, or divorced, HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 20, 1921, to Feb 15, 1922, that I last saw him alive on Feb 15, 1922, and that death occurred, on the date stated above, at 6:30 P. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma (Kneel) on white body (duration) one yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry B. Stoltz, M. D.

, 19 (Address) 1203 Light St

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificates.

17 1922

Burial Permit Clerk.

Registrar

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Probably originated  
in gland of neck.*

D 61419

Nailen 1392 W. 4 Ave.  
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61419

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1712 Thomas Ave. ST. 15 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Frank L. Nailen

## (a) RESIDENCE NO.

1712 Thomas Ave

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Abrie B. Nailen

6 DATE OF BIRTH (month, day, and year)

Jan 7, 1884

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

38

1

12

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Wash D.C.

10 NAME OF FATHER

Wm L. Anthony

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Eng.

12 MAIDEN NAME OF MOTHER

Ella Aiken

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Eng.

14

Informant  
(Address)

Abrie B. Nailen

15

17 1922

Robert P. Harrison,

19

Burial Permit Clerk

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 1920, 19 to Feb. 16, 1920.

that I last saw him alive on Feb 16, 1922.

and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH\* was as follows:

mitral stenosis

(duration) 2 yrs. 1 mos. ds.

CONTRIBUTORY  
(Secondary)

arrhythmia fibrillation

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Samuel Whitehouse M. D.

19

(Address) 1392 W. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral

DATE OF BURIAL

2-20 1922

20 UNDERTAKER

Wm Cook

ADDRESS

1392 W. North Ave.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61420

## CERTIFICATE OF DEATH.

D 61420

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2811 Frederick Rd. ST. 70 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. mos. ds.

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 71 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

female white widow

5a If married, widowed, or divorced

HUSBAND or  
(or) WIFE ofConrad Drimling6 DATE OF BIRTH (month, day, and year) Sept 26 / 1837

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.844

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Germany

10 NAME OF FATHER

Bernard Lang11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Germany

12 MAIDEN NAME OF MOTHER

Eleanor Von Bismarck13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Germany

14

Informant  
(Address)Miss Bertha W. Drimling  
2811 Frederick Road

15

Robert P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16 1922

17

I HEREBY CERTIFY, That I attended deceased from  
Jan 3 1922 to Feb. 16 1922.  
That I last saw him alive on Feb. 15 1922.and that death occurred, on the date stated above, at 1:40 a. m.

The CAUSE OF DEATH\* was as follows:

Valvular Heart-disease  
(Mitral regurgitation)

(duration)

Many yrs. mos. ds.CONTRIBUTORY  
(Secondary)Anaemia

(duration)

yrs. 2 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

Marshall S. Smith

M. D.

Feb 16 1922 (Address) 118 N. Calhoun St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Landon Park Feb. 18/1922

20 UNDERTAKER

ADDRESS

Wm. Pook 502 E. Pratt St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificate.

Burial Permit (1511)

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61421

## CERTIFICATE OF DEATH.

61421

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *6 N. Kenwood an* ST.; *6* WARD)

## 2-FULL NAME

*William J. Walsh*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. *6 N. Kenwood an* ST.; *6* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Winifred Walsh*6 DATE OF BIRTH (month, day, and year) *June 5<sup>th</sup> 1868*7 AGE Years *53* Months *8* Days *08* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Foreman in*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Shunt Packing Plant*

(c) Name of employer

*Shaw & Co.*

9 BIRTHPLACE (city or town) (State or country)

*City*

10 NAME OF FATHER

*William Walsh*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ireland*

12 MAIDEN NAME OF MOTHER

*Walterine Kennedy*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ireland*

## 14

Informant (Address)

*Winifred Walsh 6 N. Kenwood an*

## 15

Filed

*Robert E. Harrison, Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 15* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *Jan 11*, 19 *22*, to *Feb 14*, 19 *22*, and that I last saw him alive on *Feb 14*, 19 *22*.and that death occurred, on the date stated above, at *12:30* a.m.

The CAUSE OF DEATH\* was as follows:

*Chronic Nephritis*CONTRIBUTORY (Secondary) *Diabetes Mellitus* (duration) *1* yrs. *3* mos. ds.(duration) yrs. *6* mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *John F. Orman* M. D.(Address) *35-4 Potomac St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*West Cathedral Cem**2-18-1922*

20 UNDERTAKER

ADDRESS *300 E Baltimore**J. G. Moran**E. Baltimore*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

FEB 17 1922

Burial Permit Clerk.

D 61422 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

91-001 D 61422

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 - Harford Ave. ST. 9 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Robert F. Brown

## (a) RESIDENCE NO.

1613 Harford Ave. ST.

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Elizabeth Brown

## 6 DATE OF BIRTH (month, day, and year)

Oct-30-1862

## 7 AGE

59 yrs

Years

Months

Days

LESS than 1 day hrs. or min.

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Despatcher 086

## (b) General nature of industry, business, or establishment in which employed (or employer)

Taxi cab Co.

## (c) Name of employer

Mr. Cloud

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore City

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

## 14

Informant (Address)

Mrs. Eliza Brown 1613 Harford Ave.

## 15

Robert F. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb 15 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb 1st 1922 to Feb 15 1922.

that I last saw him alive on Feb 15 1922

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH\* was as follows:

Aortic Aneurysm

(duration) yrs. 4 mos. ds.

## CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death? Not known

## Did an operation precede death?

No Date of

## Was there an autopsy?

No

## What test confirmed diagnosis?

Clinical symptoms

(Signed) Wm. O. Case, M. D.

## Feb 16 1922 (Address)

J. E. Treat

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Baltimore Cemetery

## DATE OF BURIAL

2/18/22

## 20 UNDERTAKER

George J. Ruth 1735 Harford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

7-1922

Burial Permit Clerk

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Cause unknown*



Spec.—1-10-21—M&T—1500 Bks. *Shipping papers*  
Exact statement of **CAUSE OF DEATH** in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 61423

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 61423

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1409 W. Fremont* ST., *14* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

*William H. Holton*

(a) RESIDENCE NO.

*1409 W. Fremont* ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *35* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*Colored*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Aug 1866*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*55*

*6*

*22*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*St Mary Co Md*

10 NAME OF FATHER

*William H. Holton*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*St Mary Co Md*

12 MAIDEN NAME OF MOTHER

*Nellie Butler*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Md*

14

Informant (Address)

*Sarah Thomas 1124 W. Carey St*

15

Filed

*Robert P. Harrison*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *February 16 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Dec 8 1921* to *Feb 16 1922* that I last saw him alive on *Feb 16 1922*

and that death occurred, on the date stated above, at *6:30 P. m.*

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis*

(duration) yrs. *3* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *William H. Wright* M. D.

(Address) *1209 Princeton St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*St Mary Co Md*

*Feb 18 1922*

20 UNDERTAKER

ADDRESS

*Charles Wright 1124 W. Carey St*

EB 17 1922

Trial Permit Clerk.

D 61424

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE (State or Country).

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

Robert L. Harrison,

Registrar.

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Harrison, M. D.

(Coroner.)

Feb. 16, 1922 (Address) 2000 E. Baltimore St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

B- Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION CAUSE OF DEATH in plain terms, so that it may be properly classified. Important. See instructions on back of certificate.

D 61424

Burial Permit Clerk.]

N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT-CITY OF BALTIMORE

D 61425

## CERTIFICATE OF DEATH

3860 61425

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

St. Elizabeths Home  
Eugene F. Hainsworth  
St. Elizabeths Home

ST.

WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

St. 1 yrs. 9 mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE Colored SINGLE MARRIED WIDOWED OR DIVORCED Child (Write the word)

DATE OF BIRTH May 23, 1920 (Month) (Day) (Year)

AGE 1 yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.?

OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None

BIRTHPLACE (State or country) Balto Md

NAME OF FATHER Jas. Collland

BIRTHPLACE OF FATHER (State or country) Unknown

MAIDEN NAME OF MOTHER Wilhelmina Hainsworth

BIRTHPLACE OF MOTHER (State or country) Georgia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mother Mary Pascal

(Address) St Elizabeth Home

Robert F. Harrison,

Serial Permit Clerk REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH February 16, 1922 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from January 1922, to February 14, 1922, that I saw him alive on February 14, 1922, and that death occurred, on the date stated above, at 11 A. m. The CAUSE OF DEATH\* was as follows:

Infective Endocarditis (Duration) yrs. mos. ds

Contributory (SECONDARY) (Duration) yrs. mos. ds. (Signed) Frank J. Ayd M. D. Feb 16, 1922 (Address) 2065 E. Monument St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death 8 mos. ds. In the State 1 yrs. 9 mos. ds.

Where was disease contracted, (if not at place of death?) Former or usual residence 450 E. Federal Street

PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Int Auburn Cem Feb 18, 1922

UNDERTAKER ADDRESS Jas. M. Skimmer 1625 C. Mad. St

D 61426

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61426

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE (No. 2841 Woodbrook WARD 3)

## 2. FULL NAME

Josephine B. Lilly

## (a) RESIDENCE No.

2841 Woodbrook WARD 3

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Geo. W. Lilly

## 6 DATE OF BIRTH (month, day, and year)

Feb. 28 - 1846

## 7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

751118

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Balto.

## 10 NAME OF FATHER

Thomas Yeildhall

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ind

## 12 MAIDEN NAME OF MOTHER

Eliza Sanders

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind

## 14

Informant (Address)

Geo. W. Lilly  
2841 Woodbrook

## 15

Robert P. Harrison

, 19

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb 16 19 22

## 17

I HEREBY CERTIFY That I attended deceased from

April 1 1921 to Feb 16 1922  
that I last saw him alive on Feb 15 1922and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage  
(Right Hemisphere)

## CONTRIBUTORY (Secondary)

(duration)

yrs. mos. ds.

(duration)

yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

John E. Chang M. D.

(Address)

714 W. W. Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

London Park CemeteryFeb. 18 1922

## 20 UNDERTAKER

## ADDRESS

James Dignam & Son1000 S. Paca St

Exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificates.

18 1922

Burial Permit Clerk.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61427

## CERTIFICATE OF DEATH.

REGISTERED NO. 100-001 D 61427

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *New Cath Cemetery* ST. *70* WARD)

## 2-FULL NAME

*Frederick Joseph King Jr*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE. NO.

*New Cath Cemetery*ST. *70*

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*M*

## 4 COLOR OR RACE

*W*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Single*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*no*

## 6 DATE OF BIRTH (month, day, and year)

*Feb 16-22*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*1*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Baltimore City*

## 10 NAME OF FATHER

*Malvin Knight*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ind*

## 12 MAIDEN NAME OF MOTHER

*Catherine King*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ohio*

## 14

Informant (Address)

*O Knight**New Cath Cemetery*

## 15

Filed

19

*Robert P. Harrison*

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*Feb 17 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from *Feb 16*, 19*22*, to *Feb 17*, 19*22*.that I last saw him alive on *Feb 17*, 19*22*.and that death occurred, on the date stated above, at *1 P* m.

The CAUSE OF DEATH\* was as follows:

*Ac. Broncho pneumonia*(duration) yrs. mos. *1* ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *no*Was there an autopsy? *no*What test confirmed diagnosis? *Physical findings*(Signed) *W. A. Hill*, M. D.17, 1922 (Address) *4207 Federal Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Catholic Cemetery Feb 18 1922*

## 20 UNDERTAKER

ADDRESS

*H. Hill & Son 1729 Pratt St*

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

No further history  
could be obtained

D 61428

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61428

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 135 W. West St. St. 23 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Jeffro Spedden. (C)

(Residence in Baltimore: No. 135 W. West St. St. 2 yrs. 5 mos. 23 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, Colored. 5-Single, Married, Widowed, or Divorced, Single (Write the word.)

6-DATE OF BIRTH, August 25th, 1919. (Month) (Day) (Year)

7-AGE, 2 yrs. 5 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Walter Hall. (C)

11-BIRTHPLACE OF FATHER, (State or Country), Virginia

12-NAME OF MOTHER, Gertrude Spedden. (C)

13-BIRTHPLACE OF MOTHER, (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gertrude Spedden. (C) mother

(Address) 135 W. West St.

15- Robert P. Harrison,

Filed 1922 Registrar.

18-1922 Burial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 17th, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)

Feb. 17th 1922 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mt Auburn Feb. 18, 1922

20-UNDERTAKER, ADDRESS

J. H. Brown and Son 108 N. Highland St.

D 61429

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61429

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST.

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day  
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular  
kind of work.  
(b) General nature of industry, busi-  
ness, or establishment in which  
employed (or employer).9-BIRTHPLACE,  
(State or Country).10-NAME OF  
FATHER,11-BIRTHPLACE  
OF FATHER  
(State or Country).12-MAIDEN NAME  
OF MOTHER13-BIRTHPLACE  
OF MOTHER  
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison

Registrar.

Burial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I took charge of the  
remains described above, held anthereon and from the evidence obtained by said  
thereof, and that said deceased came to death  
on the day stated above.

THE CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)

(Signed)

(Duration)

(Coroner)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,  
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN-  
SIENTS, OR RECENT RESIDENTS).At place In the  
of death...yrs....mos....ds. State...yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61430

D 61430

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. *9* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs. Augusta Regal (Regel)*(a) RESIDENCE. NO. *108 Baltimore Ave* ST. *St. Helena* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *John Regel*6 DATE OF BIRTH (month, day, and year) *Jan. 26 - 1894*7 AGE Years *28* Months *0* Days *19* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*(b) General nature of industry, business, or establishment in which employed (or employer) *at home*

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto.* (State or country) *Ind.*10 NAME OF FATHER *George Gruebler*11 BIRTHPLACE OF FATHER (city or town) *Ger.* (State or country)12 MAIDEN NAME OF MOTHER *Margaret Moser*13 BIRTHPLACE OF MOTHER (city or town) *Balto.* (State or country) *Ind.*14 Informant *John Gruebler (Regel)* (Address) *108 Baltimore Ave*15 *Robert P. Harrison,*

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 15, 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 1, 1922, to Feb 15, 1922.*that I last saw her alive on *Feb 15, 1922*and that death occurred, on the date stated above, at *10-P. m.*

The CAUSE OF DEATH\* was as follows:

*Myocardial Insufficiency*

(duration) yrs. mos. ds.

CONTRIBUTORY *Chronic Interstitial* (Secondary) *nephritis*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Unknown*Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Herman J. Doy*, M. D., 19 (Address) *St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Sacred Heart Cmw.*

## DATE OF BURIAL

*Feb. 20 1922*

## 20 UNDERTAKER

*Lily Ann Zuber*

## ADDRESS

*403 S. ...*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

1922

D 61431

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61431

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1303 Light

## 2-FULL NAME

Bordelia Allen

## (a) RESIDENCE. NO. 1303 Light

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds.

ST.: 23 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST.: 23 WARD.

(If nonresident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced (write the word)

Female White Married

5a If married, widowed, or divorced HUSBAND or (or) WIFE of David V. Allen

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14 Informant (Address)

## 15 Filed

19

Burial Permit Clerk Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/17/22 19

17 I HEREBY CERTIFY, That I attended deceased from 2/13/22, 19, to 2/17/22, 19, that I last saw her alive on 2/17/22, 19, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Paralysis

(Signed)

4/17/24

(Address)

107 E West St

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

D 61432 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61432

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: No. 2 Sr Highland ST. 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

John P. Thuma

(a) RESIDENCE NO.

2 Sr. Highland

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

20 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Celina M. Thuma

6 DATE OF BIRTH (month, day, and year)

Oct-26-1872

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

49-

3

21

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Picture Framer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Penn

10 NAME OF FATHER

Jimmie Thuma

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Penn

12 MAIDEN NAME OF MOTHER

Laura Gammon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Penn

14

Informant

Celina M. Thuma

(Address)

2 Sr Highland

15

Robert P. Harrison,

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 17 1922

17

I HEREBY CERTIFY, That I attended deceased from

2/4, 1922, to

2/17, 1922,

that I last saw him alive on

2/17, 1922,

and that death occurred, on the date stated above, at

4 P m.

The CAUSE OF DEATH\* was as follows:

Premort Convolusion, Acute, Idiopathic of the Heart

CONTRIBUTORY Chroma B. D. Hypertension, (Secondary) Acute, Idiopathic

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

2/8, 1922 (Address) 3325 E. Balt St

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oak Lawn

DATE OF BURIAL

Feb 20 1922

20 UNDERTAKER

H m Cook

ADDRESS

H. J. K.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

181922

D 61433

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61433

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hammond Hospit.* ST. *11* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Charles Bennett*(a) RESIDENCE, No. *100 Ab. Mt. Royal, an.* ST.,

WARD.

(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred *20* yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

*Male* *White* *Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Single.*6 DATE OF BIRTH (month, day, and year) *July 31-1866*7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*52*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Hotel prop.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Md.*10 NAME OF FATHER *Chas. Ab. Bennett*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Md.*12 MAIDEN NAME OF MOTHER *Isabella Raffle*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Balto.*  
*Md.*14 Informant *H. C. Hill*(Address) *Allegheny Ave. Towson*15 Filed *Robert H. Harrison* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 17, 1922*

17 I HEREBY CERTIFY, That I attended deceased from

*Jan. 30, 1922, to Feb. 16, 1922,*that I last saw him alive on *Feb. 16, 1922,*and that death occurred, on the date stated above, at *12:45 A. m.*

The CAUSE OF DEATH\* was as follows:

*Delirium Tremens*(duration) yrs. mos. ds. *18*CONTRIBUTORY  
(Secondary)*Alcoholic Coma*(duration) yrs. mos. ds. *3*18 Where was disease contracted  
If not at place of death? *100 Ab. Mt. Royal an.*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Robert J. Green*, M. D.2-17-1922 (Address) *120% Cisquith St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Greenmount Cent.**2-20 1922*

20 UNDERTAKER

ADDRESS

*William Cook**502 E. North*

FEB 18 1922

Burial Permit *5112*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.





## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61435

D 61435

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2125 Orleans ST., 6 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME John L. Humbacher(a) RESIDENCE NO. 2125 Orleans

(Usual place of abode)

ST.,

WARD

Length of residence in city or town where death occurred Life yrs. mos. ds.How long in U. S., if of foreign birth? Life yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret C. Humbacher6 DATE OF BIRTH (month, day, and year) Oct 24 - 1879

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 43 4 2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.10 NAME OF FATHER John C. Humbacher11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.12 MAIDEN NAME OF MOTHER Margaret Smith13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14

Informant Margaret C. Humbacher (Address) 2125 Orleans St.

15

FEB 18 1922 Robert P. Harrison, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to Feb 16, 1922, that I last saw him alive on Feb 16, 1922, and that death occurred, on the date stated above, at 12:30 p. m.

The CAUSE OF DEATH\* was as follows:

Valvular lesion of the Heart(duration) yrs. 1 mos. 16 ds.CONTRIBUTORY (Secondary) Cerebral Thrombosis(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Auscultation & C(Signed) Adolph C. Eisenberg, M. D.7/17 1922 (Address) 2201-03 Orleans St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Baltimore CemeteryDATE OF BURIAL Feb 20 192220 UNDERTAKER Mrs C. MillerADDRESS 2334 York

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 61436 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE (No. *2536 Fleet* ST.:2-FULL NAME *Frank J. Marchuk*(Residence in Baltimore: No. *2536 Fleet St*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. *3* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED, *Single* (Write the word.)6-DATE OF BIRTH, *Feb 14, 1922* (Month) (Day) (Year)7-AGE, *3* yrs., *3* mos., *3* ds. If LESS than 1 day, ...hrs. or...min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Bully* (b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Baltimore Md*10-NAME OF FATHER, *Frank Marchuk*11-BIRTHPLACE OF FATHER (State or Country), *Pennsylvania*12-MAIDEN NAME OF MOTHER, *Esther Kahler*13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank J. Marchuk*(Address) *2536 Fleet St*

15-

Robert F. Harrison, Filed..... 191..... Registrar.

181922 Burial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb 17, 1922* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest*, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Leaving fatal plebitis*

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary).....

(Duration)..... yrs..... mos..... ds.

(Signed) *William J. Smith* M. D. (Coroner)

191..... (Address).....

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*St. Carmel Feb. 18, 1922*

20-UNDERTAKER ADDRESS

*Johnson Weber 1803 Bank St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

D 61437

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61437

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE, NO. 812 W. Lexington ST., 18 WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

5 mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

## 4. COLOR OR RACE

## 5. Single, Married, Widowed, or Divorced, (write the word)

Male Color Married

## 5a. If married, widowed, or divorced

HUSBAND of (or WIFE of)

Jennie Brown

6. DATE OF BIRTH (month, day, and year) Dec 25, 1900

## 7. AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

21

1

22

## 8. OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9. BIRTHPLACE (city or town) (State or country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER (city or town) (State or country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant (Address)

## 15

Filed

Robert F. Harbeck

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH (month, day, and year)

Feb 16, 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Noon 6<sup>th</sup>, 1921, to Feb 16<sup>th</sup>, 1922.that I last saw him alive on Feb 15<sup>th</sup>, 1922.

and that death occurred, on the date stated above, at 8:10 p. m.

The CAUSE OF DEATH\* was as follows:

Phthisis Pulmonalis

(duration)

Indef.

ds.

## CONTRIBUTORY (Secondary)

(duration)

yrs. mos. ds.

## 18. Where was disease contracted if not at place of death?

Phila Pa

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Robb, M. D.

Address 119 N Carrollton Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19. PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Hagerstown Md

Feb. 17, 1922.

## UNDERTAKER

ADDRESS

Mrs. Katie R. Williams

114 N. Seneca St.

B 181922

Burial Permit Clerk.

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

61438

D 61438

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 552 Hanson)

ST. 17

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Unice Belle Griffin

## (a) RESIDENCE. No. 552 Hanson

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

12 mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Wife of James Griffin

## 6 DATE OF BIRTH (month, day, and year)

1874

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

47

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

Laundry

(c) Name of employer

Mr. Martin

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

## 10 NAME OF FATHER

Samuel E. Davis

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

South Carolina

## 14

Informant

(Address)

Samuel E. Davis

## 15

Filed

19

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16<sup>th</sup>, 1922

17 I HEREBY CERTIFY, That I attended deceased from

Feb. 9<sup>th</sup>, 1922, to Feb. 16<sup>th</sup>, 1922,that I last saw her alive on Feb. 15<sup>th</sup>, 1922,

and that death occurred, on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH\* was as follows:

Hemorrhage of Brain

(duration)

yrs.

mos.

ds.

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed)

J. M. Johnson

M. D.

19 (Address) 1063 Myrtle Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Auburn Cemetery

## 20 UNDERTAKER

Jno. M. Johnson

## DATE OF BURIAL

Feb. 17, 1922

## ADDRESS

1234

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state statement of OCCUPATION. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 18 1922

61439 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61439

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.; 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

James T. Boone

## (a) RESIDENCE. NO.

607 E. George

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

May 19 - 1867

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

54828

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Writer 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore md.

## 10 NAME OF FATHER

J. W. Boone

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

?

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

## 14

Informant (Address)

JOHNS HOPKINS HOSPITALRecords

## 15

Filed

Robert P. Harrison,19

Registrar

Birth Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb. 16 - 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb 6 - 1922, to Feb 16 - 1922that I last saw him alive on Feb 16 - 1922and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH\* was as follows:

Myocardial insufficiency.(duration) 2 yrs. 4 mos. — ds.

## CONTRIBUTORY

(Secondary)

Arteriosclerosis duration — yrs. — mos. — ds.

## 18 Where was disease contracted

if not at place of death?

Home.Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? None(Signed) Francis R. Diegenick M. D.16, 1922 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

St. Aubrey CemeteryFeb. 19 1922

## 20 UNDERTAKER

Jas. M. Johnson

## ADDRESS

1234 Eding St.

Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

EB 18 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61440

D 61440

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *906 Born Alley* ST. *18* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *906 Born Alley* St. *20* yrs. *10* mos. *10* da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*M.*

4-COLOR OR RACE

*Col.*5-SINGLE, *Married*  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

6-DATE OF BIRTH.

*March 4, 1873*  
(Month) (Day) (Year)

7-AGE

*49 yrs. 11 mos. 11 da.*

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Taylor*9-BIRTHPLACE,  
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER  
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

*Robert F. Harrison,**191*  
Burial Permit *181922* Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Feb. 15, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Feb. 9, 1922, to Feb. 15, 1922,*that I saw him alive on *Feb. 15, 1922,*and that death occurred, on the date stated above, at *8 P. m.*

The CAUSE OF DEATH\* was as follows:

*Brauche Pneumonia*

(Duration) .... yrs. .... mos. .... da.

CONTRIBUTORY *Acute nephritis*  
(Secondary)

(Duration) .... yrs. .... mos. .... da.

(Signed) *Wm. H. Hays* M. D.*2/16, 1922* (Address) *513 N. Calver*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death .... yrs. .... mos. .... da. In the State .... yrs. .... mos. .... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

N.B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61441

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2400 E. Baltimore ST. WARD 6)

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

2400 E. Baltimore ST. WARD 6

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John M. Ritz

6 DATE OF BIRTH (month, day, and year)

Oct 16, 1865

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

56

3

1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Balto Md.

## 9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

Patrick King

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Belia O'Donnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

John M. Ritz  
2400 E. Baltimore St

15

Filed

Robert P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 12, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 23rd, 1922, to Feb 17th, 1922, that I last saw her alive on Feb 17th, 1922, and that death occurred, on the date stated above, at 3:15 P. M.

The CAUSE OF DEATH\* was as follows:

Diabetes Mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2400 Baltimore St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical + Microscopical

(Signed) August Horn, M. D.

19 (Address) 40 E. 25th St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Druid Ridge Cemetery

20 UNDERTAKER

H. Sander &amp; Sons

DATE OF BURIAL

Feb 20, 1922

ADDRESS

1710 Flat St

B 18 1922



D 61442

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61442

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 518 Registry ST. 2 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 518 Registry St.)

## REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Male

## 4-COLOR OR RACE

White

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word)

Single

## 6-DATE OF BIRTH

Dec 10, 1847

## 7-AGE

74 yrs. 4 mos. 7 ds.

## If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Retiree

9-BIRTHPLACE,  
(State or Country).

Baltimore Md

## 10-NAME OF FATHER

John Syll

11-BIRTHPLACE OF FATHER  
(State or Country).

Baltimore Md

## 12-MAIDEN NAME OF MOTHER

Margaret Maser

13-BIRTHPLACE OF MOTHER  
(State or Country).

Baltimore Md

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. W. G. Robinson

(Address)

6011 N. East Fort Ave

## 15-

Filed

Robert P. Harrison,

191

Registrar.

Parial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

February 16, 1922

(Month) (Day) (Year)

## 17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. W. G. Robinson M. D.

(Address) 1800 N. E. Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Annapolis Md. Feb. 18, 1922

20-UNDERTAKER ADDRESS

H. Sander &amp; Sons 1710 Fleet St.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

181922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61443

D 61443

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mount Hope Retreat* ST. *28th* WARD)

## 2-FULL NAME

*Thomas W. Radford.*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE. NO.

*Mt Hope Retreat*ST. *28th* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *9* yrs. *0* mos.ds. How long in U. S., if of foreign birth? *7* yrs. *0* mos. *0* ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Married*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Wm Radford*

## 6 DATE OF BIRTH (month, day, and year)

*Unknown*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*5-1* years *0* months *0* days

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Labor*

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Baltimore, Maryland*

## 10 NAME OF FATHER

*John Radford*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ireland*

## 12 MAIDEN NAME OF MOTHER

*Elizabeth Hestell*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ireland*

## 14

Informant (Address)

*Records of Mt Hope Retreat, Mt Hope Retreat*

## 15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 17* 1922

17

I HEREBY CERTIFY, That I attended deceased from *May 17*, 1922, to *Feb 17*, 1922,that I last saw him alive on *Feb 17*, 1922,and that death occurred, on the date stated above, at *11:45 A. M.*

The CAUSE OF DEATH\* was as follows:

*Epilepsy (chronic)**11* yrs. *0* mos. *0* ds. (duration)

CONTRIBUTORY (Secondary)

*mania Epileptica**11* yrs. *0* mos. *0* ds. (duration)18 Where was disease contracted *Baltimore Md*  
If not at place of death?Did an operation precede death? ☒ Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Frank J. Lannery* M. D.*Feb 17*, 1922 (Address) *Mt Hope Retreat*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Cathedral Cemetery**Feb 18*, 1922

20 UNDERTAKER

ADDRESS *2236**Wm J. Hartweg, N. Baltimore St*

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. - 1-10-21-M&T-1500 Rls.  
D 61444  
HEALTH DEPARTMENT-CITY OF BALTIMORE  
CERTIFICATE OF DEATH.  
100-001  
REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)  
1. PLACE OF DEATH  
CITY OF BALTIMORE: (No. 201 W. Mount ST., 19 WARD)  
2. FULL NAME  
Bernard Edward Johnson  
(a) RESIDENCE NO. 201 W. Mount ST., WARD  
(Usual place of abode)  
(If non-resident give city or town and State)  
Length of residence in city or town where death occurred yrs. 5 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.  
PERSONAL AND STATISTICAL PARTICULARS  
3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)  
Male White Single  
5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of  
6 DATE OF BIRTH (month, day, and year) Aug 16 - 21  
7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
5 28  
8 OCCUPATION OF DECEASED  
(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer  
9 BIRTHPLACE (city or town) (State or country)  
10 NAME OF FATHER  
11 BIRTHPLACE OF FATHER (city or town) (State or country)  
12 MAIDEN NAME OF MOTHER  
13 BIRTHPLACE OF MOTHER (city or town) (State or country)  
14 Informant (Address)  
15 Filed 19 Registrar  
16 DATE OF DEATH (month, day, and year) Feb 16 1922  
17 I HEREBY CERTIFY, That I attended deceased from Feb 15 - 1922, to Feb 17 - 1922, that I last saw her alive on Feb 17, 1922, and that death occurred, on the date stated above, at 230 p m.  
The CAUSE OF DEATH\* was as follows:  
Bronchio pneumonia  
CONTRIBUTORY (Secondary) (duration) yrs. 5 mos 28 ds.  
18 Where was disease contracted if not at place of death? 201 W. Mount ST.  
Did an operation precede death? Date of  
Was there an autopsy?  
What test confirmed diagnosis?  
(Signed) Dr. J. W. Harrison, M. D.  
214 1922 (Address) 705 E. W. Ave.  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)  
19 PLACE OF BURIAL, CREMATION OR RE- MOVAL  
20 UNDERTAKER  
DATE OF BURIAL  
ADDRESS  
R 18 1922 Burial Permit Clerk.

Spec. - 1-10-21-M&T-1500 Rls.

D 61444

HEALTH DEPARTMENT-CITY OF BALTIMORE

D 61444

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 201 W. Mount ST., 19 WARD)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 15 - 1922, to Feb 17 - 1922, that I last saw her alive on Feb 17, 1922,

and that death occurred, on the date stated above, at 230 p m.

The CAUSE OF DEATH\* was as follows:

(duration) yrs. 5 mos 28 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 3 mos.

18 Where was disease contracted if not at place of death? 201 W. Mount ST.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. J. W. Harrison, M. D.

214 1922 (Address) 705 E. W. Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61445

D 61445

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Lombard &amp; June St.

ST.: 22 WARD

2-FULL NAME

Samuel Brown

(a) RESIDENCE. NO.

29 Lee St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

5 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Negro

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1892.

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

30

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Edward Brown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Victoria ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

14

Informant (Address)

Victoria Brown  
Newberry, Charles Co., Md.

15

Filed

Robert P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

2/13 1922

17

I HEREBY CERTIFY, That I attended deceased from

2/12 1922, to 2/13 1922,

that I last saw him alive on 2/13 1922

and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH\* was as follows:

Acute Pulmonary Tuberculosis

(duration)

yrs.

mon.

21 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mon.

ds.

18 Where was disease contracted

If not at place of death?

Home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Physical exam. etc.

(Signed)

R. J. Tyler

M. D.

, 19 (Address)

University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

HOPKINS HOSPITAL

20 UNDERTAKER

ADDRESS

Commissioner Health.

FEB 13 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

8.

FEB 18 1922

Burial Permit Clerk.



Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

15793 D 61446

CERTIFICATE OF DEATH.

31 D 61446

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL, ST.

WARD) 7

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Thomas Johnson

(a) RESIDENCE. NO.

1003 E. Madison ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

ys.

mos.

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 21, 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

4

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

William Copeland

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Lillie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md.

14

Informant (Address)

JOHNS HOPKINS HOSPITAL, Records

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 17, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 3, 1922, to Feb 17, 1922

that I last saw him alive on Feb 17, 1922

and that death occurred, on the date Feb 17, 1922, at 7:45 a.m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis Pulmonary

(duration) unknown yrs. mos. ds.

CONTRIBUTORY Tuberculosis of cerebellum (Secondary)

(duration) 1 yrs. 20 mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy & tuberculin

(Signed) Archie G. Stewart M. D.

17, 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Laurel Cem. Feb 15, 1922

20 UNDERTAKER ADDRESS

Jas. M. Skinner, 625 E. Madison St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

D 61447

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 D 61447

## PLACE OF DEATH

CITY OF BALTIMORE (No.

407 5 T Boulevard

ST.

WARD)

REGISTERED NO. C

FULL NAME

Sophia Haffel

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

407 5 T Boulevard

St.; yrs., 50 mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female	4-COLOR OR RACE White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow (Write the word.)
6-DATE OF BIRTH Sept 12, 1893 (Month) (Day) (Year)		
7-AGE 69 yrs. 5 mos. 4 ds. If LESS than 1 day, hrs. or min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		
9-BIRTHPLACE (State or Country) Germany		
PARENTS.	10-NAME OF FATHER Karl Vollman	
	11-BIRTHPLACE OF FATHER (State or Country) Germany	
	12-MAIDEN NAME OF MOTHER Dora Haffel	
	13-BIRTHPLACE OF MOTHER (State or Country) Dachau	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Dora Haffel

(Address)

407 5 T Boulevard

15-

Robert F. Harrison,

Filed 191

Burial Permit Clerk:

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Feb 16, 1964  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, an

autopsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry S. M. D.

Feb 18, 1964 (Address) 1800 York St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Oak Lawn Cemetery, Feb 19, 1964

20-UNDERTAKER ADDRESS

H. H. H. Co. 500 N. Ave.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHOTODUPLICATIONS OF THIS FORM ARE NOT PERMITTED. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

181922

61448

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61448

## CERTIFICATE OF DEATH.

179

61448

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 122 St 23rd

ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John Wesley Shannonhouse

(a) RESIDENCE

No. 122 St 23rd

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3 SEX

Male

4 COLOR OR RACE

col

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Lilly Porter Shannonhouse

6 DATE OF BIRTH (month, day, and year)

Mar 7 - 1846

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

75

10

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer at

(b) General nature of industry, business, or establishment in which employed (or employer)

General work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Elizabeth City North Carolina

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

N.C.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

N.C.

14

Informant (Address)

Wm. Shannonhouse 122 St 23rd St

15

FEB 19 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

16 DATE OF DEATH (month, day, and year)

Feb 16 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 20, 1922, to Feb 16, 1922,

that I last saw him alive on Feb 15, 1922,

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic Bronchitis (duration) 6 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edward J. Hines, M. D.

, 19 (Address) 1707 E. Howard St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

National Cemetery

2/20

1922

20 UNDERTAKER

ADDRESS

Mrs. J. A. Hooper 406 N. Bond St.







mation should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 9-19-H. P. Co.—1000 Bks.				HEALTH DEPARTMENT—CITY OF BALTIMORE		61450
1-PLACE OF DEATH				CERTIFICATE OF DEATH.		X/29 61450
CITY OF BALTIMORE: (No. <u>JOHNS HOPKINS HOSPITAL ST.</u> )				WARD) <u>7</u>		REGISTERED NO. <u>61450</u> (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2-FULL NAME <u>Mrs. Pearl McElroy</u>						
(a) RESIDENCE. No. <u>617 So. Valley St.</u>				WARD <u>Tampa, Fla.</u>		
(Usual place of abode)				(If nonresident give city or town and State)		
Length of residence in city or town where death occurred <u>10 yrs.</u>				How long in U. S., if of foreign birth? <u>10 yrs.</u>		
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Married</u>				
5a If married, widowed, or divorced <u>Deceased</u> (or) WIFE of <u>Deane McElroy</u>						
6 DATE OF BIRTH (month, day, and year) <u>Feb 3-1885</u>						
7 AGE	Years <u>36</u>	Months <u>5</u>	Days <u>14</u>	If LESS than 1 day, hrs. or min.		
8 OCCUPATION OF DECEASED						
(a) Trade, profession or particular kind of work <u>Domestic</u>						
(b) General nature of industry, business, or establishment in which employed (or employer) <u>037</u>						
(c) Name of employer						
9 BIRTHPLACE (city or town) <u>Ohio</u> (State or country)						
10 NAME OF FATHER <u>Charles Selmore</u>						
11 BIRTHPLACE OF FATHER (city or town) <u>Ohio</u> (State or country)						
12 MAIDEN NAME OF MOTHER <u>Nannie Marshall</u>						
13 BIRTHPLACE OF MOTHER (city or town) <u>Kentucky</u> (State or country)						
14 Informant <u>Records</u> (Address)						
15 <b>FEB 19 1922</b> <u>ROBERT R. KRAUTER</u> Burial Permit Clerk						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH (month, day, and year) <u>Feb. 17-1922</u>						
17 I HEREBY CERTIFY, That I attended deceased from <u>Feb. 2-1922</u> , 1922, to <u>Feb. 17-1922</u> , 1922, that I last saw <u>her</u> alive on <u>Feb. 17-1922</u> , 1922, and that death occurred, on the date stated above, at <u>4:10 P.M.</u>						
The CAUSE OF DEATH* was as follows: <u>CHRONIC INTERSTITIAL NEPHRITIS</u> <u>ARTERIOSCLEROSIS</u> <u>HYPERTENSION</u> (duration) <u>2</u> yrs. — mos. — ds.						
CONTRIBUTORY (Secondary) (duration) — yrs. — mos. — ds.						
18 Where was disease contracted — if not at place of death? —						
Did an operation precede death? <u>No</u> Date of —						
Was there an autopsy? —						
What test confirmed diagnosis? —						
(Signed) <u>John J. Dorsey</u> , M. D. I. W. N.						
*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)						
19 PLACE OF BURIAL, CREMATION OR REMOVAL <u>Tampa Florida</u>				DATE OF BURIAL <u>2-18 1922</u>		
20 UNDERTAKER <u>Henry W. Eukin, Sons &amp; Co.</u>				ADDRESS <u>W. J. Fallon Orchard</u>		

61451 HEALTH DEPARTMENT—CITY OF BALTIMORE 001 61451  
D 61451

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Union Memorial Hospital

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

CITY OF BALTIMORE: (No.

1514 Division

ST.

WARD)

2-FULL NAME

Mr. Edward Horton Rouzer

(a) RESIDENCE. NO.

#327 4 M. C. A.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

5

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb 12, 1892

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

30

-

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Clerk

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

Naval Academy, Annapolis

9 BIRTHPLACE (city or town)  
(State or country)Frederick  
Md.

10 NAME OF FATHER

Harvey Rouzer

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Baltimore  
Md.

12 MAIDEN NAME OF MOTHER

Gertrude Lamar

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Frederick  
Md.

14

Informant  
(Address)Russell Rouzer  
Washington and

15

FEB 19 1922

ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 18 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 14 1922, to Feb 18 1922,

that I last saw him alive on Feb 18 1922,

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia - bilateral

(duration) yrs. mos. 7 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Balt.

Did an operation precede death? 20 Date of

Was there an autopsy? 20

What test confirmed diagnosis?

(Signed)

Paul W. Sutton

, M. D.

, 19 (Address)

W. M. Id.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Md.

Feb 19 1922

20 UNDERTAKER

ADDRESS

Chas. H. Black 742 W. North Ave.

# 61452 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61452

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Hospital ST.: 25 WARD)

2-FULL NAME George Link

(a) RESIDENCE. NO. Stone House Cove ST.      WARD.       
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1851  
7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
70 -- --

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fisherman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,  
(State or country) Maryland

10 NAME OF FATHER Thos. Link

11 BIRTHPLACE OF FATHER (city or town) Balto.,  
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Baltimore,  
(State or country) Maryland

14 Informant Hospital Records,  
(Address) Municipal Hospital

15 Filed FEB 19 1922 ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 1922

17 I HEREBY CERTIFY, That I attended deceased from February 16, 1922, to February 17, 1922, that I last saw him alive on February 16, 1922, and that death occurred, on the date stated above, at 5:45 A.M.  
The CAUSE OF DEATH\* was as follows:

Carcinoma of rectum

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings  
(Signed) P. J. Brumback M. D.

2/17/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cedar Hill Cms 2/20 1922

20 UNDERTAKER Margaret G. Flynn ADDRESS 1422 Highland St.

# 61453 HEALTH DEPARTMENT—CITY OF BALTIMORE

## D 61453 CERTIFICATE OF DEATH.

61453  
90 D 61453

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 William ST.: 24 WARD)

## 2-FULL NAME

Mary C. Caldwell

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE. NO.

1014 William ST.: 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Caldwell

6 DATE OF BIRTH (month, day, and year) 12/15/1859

7 AGE Years 60 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Nothing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Timothy Lashin

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary Lashin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

## 14

Informant (Address)

John Caldwell 1014 William

## 15

Filed

FEB 19 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1922, to Feb 17 1922

that I last saw him alive on Feb 16 1922,

and that death occurred, on the date stated above, at 12:05 a.m.

The CAUSE OF DEATH\* was as follows:

Senile dementia

CONTRIBUTORY (Secondary)

(duration)

yrs. 3 mos. ds.

(duration)

yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

1922 Address 1315 1/2 St. N.W.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cyn

2/20 1922

20 UNDERTAKER

ADDRESS

Margaret R. Ryan

14 W. 14th St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61454

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 437 E. Fort Ave ST., 24 WARD)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

437 E Fort Ave

ST.,

WARD

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

29

3

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Steam Pipe fitters

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

FEB 18 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. — 1922, to Feb. 17, 1922.

that I last saw him alive on Feb. 17, 1922.

and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

probably (duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Mark F. Hoar, M. D.

2-17-1922 (Address) 414 Proj. Bldg.

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

Rockville Montgomery Co Md Feb 20 1922

20 UNDERTAKER

ADDRESS

John F. Denny 715 Light

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE 61455

## CERTIFICATE OF DEATH.

D 61455

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 Dickman ST., 23 WARD)

## 2-FULL NAME

Royce Van Mallonee

## (a) RESIDENCE NO.

215 Dickman ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 10 mos. 13 ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

April 4 1921

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1013

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Balto. Md

## 10 NAME OF FATHER

Charles O. Mallonee

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Brooklyn Md

## 12 MAIDEN NAME OF MOTHER

Carole W. Mundy

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Taphanack Va

## 14

Informant (Address)

Charles O. Mallonee 215 Dickman St

## 15

Filed

FEB 13 1922 Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 192217 I HEREBY CERTIFY, That I attended deceased from July 8, 1922 to July 17, 1922, that I last saw him alive on July 19, 1922, and that death occurred, on the date stated above, at 5-45 a.m. The CAUSE OF DEATH\* was as follows:Cerebral EmbolismCONTRIBUTORY (Secondary) Skull fracture (duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? In homeDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physical(Signed) H. H. H. H. H., M. D.19 (Address) 1341 18th St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cedar Hill Cem

DATE OF BURIAL

Feb 20 1922

20 UNDERTAKER

John H. Deary

ADDRESS

715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61456

## CERTIFICATE OF DEATH.

90 D 61456

### 1-PLACE OF DEATH

City of BALTIMORE: (No. 925 Peach Al. St. 23 Ward)

Registered No. C. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### 2-FULL NAME

Henderson Johnson. (C).

55

(Residence in Baltimore: No. ....

925 Peach Al.

St.; yrs. .... mos. .... ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male.	4-COLOR OR RACE, Colored.	5-Single, Married, Married, Widowed, or Divorced, (Write the word.)
6-DATE OF BIRTH, Do not know.		
7-AGE, 55 yrs. .... mos. .... ds.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer. (b) General nature of industry, business, or establishment in which employed (or employer).		

9-BIRTHPLACE,  
(State or Country),  
Baltimore Md.

PARENTS.	10-NAME OF FATHER, Do not know.
	11-BIRTHPLACE OF FATHER, (State or Country), Do not know.
	12-MAIDEN NAME OF MOTHER, Do not know.
	13-BIRTHPLACE OF MOTHER, (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert L. Parham. (C).

(Address) 649 W. Lee Street.

15-

Filed FEB 19 1922 ROBERT R. KRAUTER,  
Burial Permit Clerk.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,  
February 16th, 1922.

17- I HEREBY CERTIFY, That, I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Valvular Disease of the Heart.

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY  
(Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed) H. R. Reinhardt, M. D.

Feb. 18th 1922 (Address) 1014 S. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,  
mt auburn cemetery

DATE OF BURIAL,  
2/19/22

20-UNDERTAKER,  
R. L. Parham

ADDRESS,  
649 W Lee st





## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61458

## CERTIFICATE OF DEATH.

31 D 61458

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 N. Curley ST.; 5 WARD)

## REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James R. Spencer(Residence in Baltimore: No. 515 N. Curley St.; 42 yrs., 10 mos., 30 da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE.

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

## 6-DATE OF BIRTH.

Mar 18<sup>th</sup>, 1879  
(Month) (Day) (Year)

## 7-AGE.

42 yrs., 10 mos., 30 da.

If LESS than 1 day.

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer  
040

## 9-BIRTHPLACE, (State or Country).

Balto City

## 10-NAME OF FATHER.

George Spencer

## 11-BIRTHPLACE OF FATHER, (State or Country).

City

## 12-MAIDEN NAME OF MOTHER.

Margaret Landin

## 13-BIRTHPLACE OF MOTHER, (State or Country).

City

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Julia Spencer(Address) 515 N. Curley St.

## 15-

FEB 19 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

Feb 17, 1912  
(Month) (Day) (Year)

## 17-I HEREBY CERTIFY, That I attended deceased from

12/15 1911, to 2/17 1912that I saw him alive on Feb-16 1912,and that death occurred, on the date stated above, at 6 PM m.

The CAUSE OF DEATH\* was as follows:

Pal. Pethysis

(Duration) ... yrs. ... mos. ... ds.

## CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. H. France

M. D.

115, 1011. (Address) 2459 W. 10th St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

1st German Cem

## DATE OF BURIAL.

Feb 20, 1922

## 20-UNDERTAKER

Peter Nicolaus

## ADDRESS

2046 Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61459

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 W. Baltimore St. ST., 19 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Henry Fuchs

(a) RESIDENCE NO. 1710 W. Baltimore St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of Elizabeth Fuchs

6 DATE OF BIRTH (month, day, and year) March 27<sup>th</sup> 1853

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

68

10

21

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired Barber 004

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Germany

10 NAME OF FATHER Philip Fuchs

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER Phillippino Allpeter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

## 14

Informant

Mrs. Elizabeth Fuchs

(Address)

1710 W. Baltimore St.

## 15

FEB 19 1922

ROBERT N. KRAUTER,

Registrar

## 16

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Louson Park Cem

20 UNDERTAKER

Joseph B Cook

DATE OF BURIAL

2/20/22

19

ADDRESS

1003 N. Balto

St

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17<sup>th</sup> 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 9 1922 to Feb. 17 1922. that I last saw him alive on Feb 17 1922.

and that death occurred, on the date stated above, at 5.55 A. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration)

yrs.

6 mos

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Feb. 18 1922

Address

101 N. Carey

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61460

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61460

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1015 E Monument* ST. *5* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1015* *Monument* St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*Male*

4-COLOR OR RACE.

*White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

*Unknown*

6-DATE OF BIRTH.

(Month) (Day) (Year) *1*

7-AGE.

*58* yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

*OOD*

9-BIRTHPLACE.

(State or Country),

*Don't know*

10-NAME OF FATHER.

*Don't know*

11-BIRTHPLACE OF FATHER.

(State or Country),

*Don't know*

12-MAIDEN NAME OF MOTHER.

*Don't know*

13-BIRTHPLACE OF MOTHER.

(State or Country),

*Don't know*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Paul Huber*

(Address)

*Collington Club*

15-

FILED

*FEB 19 1922*

*ROBERT B. KRAUTER*

Registrar.

Death Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

*Feb 17*, 19*22*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

to find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Chronic Infective Myocarditis*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *R. B. Krauter* M. D.

(Coroner.)

*2-19*, 19*22*. (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

*Baltimore Cemetery*

DATE OF BURIAL.

*Feb 20*, 19*22*

20-UNDERTAKER

*Robt L Turner*

ADDRESS

*1444 Broadway*

D 61461

## HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001  
D 61461

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1818 E Federal ST., 8 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Andrew F Rock

## (a) RESIDENCE NO.

1818 E Federal ST.,

## WARD

(Usual place of abode)  
Length of residence in city or town where death occurred40 yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofBarbara Rock

## 6 DATE OF BIRTH (month, day, and year)

Dec 10 1862

## 7 AGE

Years

Months

Days

LESS than  
1 day, hrs.  
or min.5927

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Finishing Plumbing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Norfolk Va

## 10 NAME OF FATHER

Michael S Rock

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

## 12 MAIDEN NAME OF MOTHER

Bridget Conroy

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

## 14 Informant (Address)

Barbara Rock  
1818 E Federal

## 15

Filed

FEB 19 1922ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 192217 I HEREBY CERTIFY, That I attended deceased from 2/15, 1922, to 2/17, 1922.that I last saw him alive on 2/17, 1922.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Pneumonia Lobar

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Asc B Ordener

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

24 22 AddressDr. J. H. Jones M. D.  
2030 N Eddy

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

Baltimore CountyFeb 21 1922

## 20 UNDERTAKER

ADDRESS 442Robt L Turner Broadway

Physicians should state Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

001

74-001

61462

REGISTERED NO. C

CERTIFICATE OF DEATH

D 61462

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 E. 20<sup>th</sup> St. 9<sup>th</sup> WARD)

2-FULL NAME Charles F. Scherz

(Residence in Baltimore: No. 515 E. 20<sup>th</sup> St. 70 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male

4-COLOR OR RACE white

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6-DATE OF BIRTH Sept 25 1847

7-AGE 74 yrs. mos. ds. or min.?

8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) retired

9-BIRTHPLACE (State or country) Germany

PARENTS

10-NAME OF FATHER Fred. O. Scherz

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard W. Scherz

(Address) 515 E. 20<sup>th</sup> St.

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH July 17 1922

I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1921, to July 17, 1922, that I saw him alive on July 16, 1922, and that death occurred, on the date stated above, at 7<sup>00</sup> a.m.

The CAUSE OF DEATH\* was as follows:

Chronic Sclerosis

Contributory (SECONDARY) Central Apoplexy

(Signed) George A. Hartman M. D.

July 15, 1922 [Address] 2214 Mayfield Pl.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Parkwood Cem.

DATE OF BURIAL July 20 1922

20-UNDERTAKER John Ottitchell

ADDRESS 1201 N. Bayview

26616

191

ROBERT R. KRAUTEN,

Burial Permit Clerk

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61463

## CERTIFICATE OF DEATH.

90 D 61463

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

ST.: 13 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed or Divorced (write the word)

Male

White

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Cora E. Miller

6 DATE OF BIRTH (month, day, and year)

Aug 11 1886

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

65

6

6

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer)

Merchant

(c) Name of employer

Self

9 BIRTHPLACE (city or town) (State or country)

Carroll Co Md

10 NAME OF FATHER

Chas Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Carroll Co Md

12 MAIDEN NAME OF MOTHER

Elizabeth Redding

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mrs Cora E. Miller 1014 Falls Road

15

FEB 19 1922

ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1922

17

I HEREBY CERTIFY, That I attended deceased from

May 1 1922 to Feb 17 1922

that I last saw him alive on 2/17 1922

and that death occurred, on the date stated above, at 11 40 P.M.

The CAUSE OF DEATH\* was as follows:

Chronic valvular heart Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) G. W. D. M. D.

(Address) 2020 N. Charles

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Miller Sta. Carroll Co Md Feb 20 1922

20 UNDERTAKER

J. S. Marshall 3539 Fall Rd

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

61464

57 D 61464

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Hebrew Hospital, Bkch. Med

ST.: 15 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mr. Louis Lesner

## (a) RESIDENCE. No.

2100 N. Pulaski

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

38 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

30 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Rebecca Lesner

6 DATE OF BIRTH (month, day, and year)

1855

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Shoe-Maker 858

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Russia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant  
(Address)Jack Lewis  
1439 E. Baltimore

15

FILED

JOSEPH H. KRAUTER  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 17, 1922

17

I HEREBY CERTIFY, That I attended deceased from

December 14, 1921, to February 17, 1922.

that I last saw him alive on February 17, 1922.

and that death occurred, on the date stated above, at 5:40 P. m.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY  
(Secondary)

Diabetes with Gangrene of foot.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

if not at place of death? At home

Did an operation precede death? Yes Date of February 15, 1922

Was there an autopsy? No

What test confirmed diagnosis? Determination of sugar in urine and

(Signed) Louis Sachs, M. D.

4/7, 1922 Address) The Hebrew Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Residals

2/19/22

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E. Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 61465

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

17 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

17 yrs.

mos.

ds.

ST.

WARD.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Widower

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Rachel Esser

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

Clothing

(c) Name of employer

Mens

9 BIRTHPLACE (city or town)  
(State or country)

Russia

10 NAME OF FATHER

Harry Esser

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Yetta

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Russia

14

Informant  
(Address)Jack Lewis  
1411 E. Balt St

15

Filed

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

ST.

WARD)

3

ST.

WARD.

(If nonresident give city or town and State)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1922

17

I HEREBY CERTIFY, That I attended deceased from

Wed. Feb 15, 1922, to Sun. Feb 19, 1922

that I last saw him alive on Sun Feb 19, 1922

and that death occurred, on the date stated above, at 1:15 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Thrombus  
Cerebral Hemorrhage

(duration) yrs. mos. 9 ds.

CONTRIBUTORY  
(Secondary)

Terminal Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

914 E. Pratt St

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed) Moses Paulson, M. D.

, 19 (Address) Hebrew Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Rosedale

2/19 1922

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E. Balt



N. B.—Every item of information should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61466 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61466

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 906 S. Charles St. St., 23 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Joel Stern.  
(Residence in Baltimore: No. 906 S. Charles St. St.; yrs. 65 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-Single, Widowed, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, November 14th, 1888, 1 (Month) (Day) (Year)

7-AGE, 68 yrs. 2 mos. 2 ds. If LESS than 1 day, hrs. oc. min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Retired Baker. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Germany.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER, (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Stern. (son).

(Address) 906 S. Charles St.

15-

Filed

FEB 19 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 16th, 1922, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Organic Disease of the Heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signature) E. M. Pennington, M. D. (Coroner)

Feb. 17th, 1922, (Address) 1017 S. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Cheb Shalom Cem. 2/19, 1922

20-UNDERTAKER, ADDRESS

David Sondheim Royal Ave.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61467

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Emerson & Morgan Circle*  
CITY OF BALTIMORE (No. *23 rd & oak* ST. *15* WARD)  
2-FULL NAME *Philly. Hall*  
(Residence in Baltimore: No. *608 Collett st* St. *15* mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>male</i>	4-COLOR OR RACE, <i>col.</i>	5-SINGLE, MARRIED, WIDOWER, OR DIVORCED, <i>Single</i> (Write the word.)
6-DATE OF BIRTH, <i>not known</i> , 1 (Month) (Day) (Year)		
7-AGE, <i>34</i> yrs. mos. ds.		8-IF LESS than 1 day, hrs. or min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work, <i>Devin or</i> (b) General nature of industry, business, or establishment in which employed (or employer), <i>Coal Cart</i>		
9-BIRTHPLACE, (State or Country), <i>Maryland</i>		
PARENTS.	10-NAME OF FATHER, <i>Thos. Hall</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>Md.</i>	
	12-MAIDEN NAME OF MOTHER, <i>Lusie Gray</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Maryland</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Charles Thomas*  
(Address) *1027 Stockton St*

15- **FEB 19 1922** **ROBERT R. KRAUTER,**  
Filed 191 Burial Permit *Black*

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *Feb 16*, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy, or inquiry thereon and from the evidence obtained by and on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Cholera*  
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *John J. Morgan* M. D.

(Coroner) *John J. Morgan*

(Address) *1322 Roland*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Mt. Auburn* DATE OF BURIAL, *19 Feb 1922*

20-UNDERTAKER, *Ed. Ringgold* ADDRESS, *196 3rd Carey St*

1331468

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7)

JOHNS HOPKINS HOSPITAL

ST.:

WARD)

## 2-FULL NAME

Maule B. Blackburn

## (a) RESIDENCE. NO.

(Usual place of abode)

Boone N.C.

WARD

N. Carolina

Length of residence in city or town where death occurred

Boone N.C.

How long in U. S. If of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Martha Blackburn

## 6 DATE OF BIRTH (month, day, and year)

Aug. 21-1858

## 7 AGE

Years

Months

Days

If LESS than  
1 day, .... hrs.  
or .... min.

63

5

27

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

N.C.

## 10 NAME OF FATHER

Edmund Blackburn

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

N.C.

## 12 MAIDEN NAME OF MOTHER

Cynthia Hodges

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

N.C.

## 14

Informant  
(Address)

JOHNS HOPKINS HOSPITAL

Records

## 15

Filed

FEB 19 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb. 17<sup>th</sup> 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb 16<sup>th</sup>, 1922, to Feb. 17<sup>th</sup>, 1922,that I last saw him alive on Feb. 17<sup>th</sup>, 1922,

and that death occurred, on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage.

(duration) 3 hours mos. ds.

CONTRIBUTORY  
(Secondary)

Bacterial endocarditis

(duration) yrs. 4 mos. ds.

## 18 Where was disease contracted

if not at place of death? Boone N.C.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Bowler Adams, M. D.

, 19 (Address) Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Boone, N. Carolina Feb. 19 1922

## 20 UNDERTAKER

## ADDRESS

William E. Schaeffer 1816 N. St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 61468

X 74-001

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61469

## CERTIFICATE OF DEATH.

90 D 61469  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2420 Wilkens Ave ST.: 20 WARD)2-FULL NAME Catherine Mahon(a) RESIDENCE. NO. 2420 Wilkens Ave ST., 20 WARD.  
(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of  
(or) WIFE of Late John J. Mahon6 DATE OF BIRTH (month, day, and year) Mar 17, 18527 AGE Years 69 Months 10 Days 30 If LESS than 1 day, hrs. or min.8 OCCUPATION OF DECEASED Retired

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland  
(State or country)10 NAME OF FATHER Michael Patterson11 BIRTHPLACE OF FATHER (city or town) Ireland  
(State or country)12 MAIDEN NAME OF MOTHER Not known13 BIRTHPLACE OF MOTHER (city or town) Ireland  
(State or country)14 Informant Annie Pearson(Address) 256 5 Frederick Ave15 Filed 19 ROBERT H. KRAUTER  
RegistrarFEB 19 1922 Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 192217 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1922 to Feb 16, 1922  
that I last saw her alive on Feb 16, 1922  
and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH\* was as follows:

acute dilatation of heart

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)Chronic Coronary Heart Disease (duration) yrs. mos. ds.18 Where was disease contracted —  
If not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Cerebral Pressure(Signed) Asa J. Bessels, M. D.2-17, 1922 (Address) 256 5 Frederick Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Peter's CemeteryFeb 20 1922

20 UNDERTAKER

Harry H. Witzke

ADDRESS

15314 Lantana

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



D 61470 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61470

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: Municipal Tuberculosis Hospital WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Woelfer

(a) RESIDENCE. NO. 2023 E. Lombard st. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Max Woelfer

6 DATE OF BIRTH (month, day, and year) May 20, 1888

7 AGE Years 33 Months 8 Days 28 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Herman Miller

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Henrietta German

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Hospital Records (Address) M. T. H.

15 FEB 19 1922 ROBERT R. KRAUTER, Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17, 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1922 to Feb. 17, 1922.

that I last saw her alive on Feb. 17, 1922.

and that death occurred, on the date stated above, at 4.45 p. m.

The CAUSE OF DEATH\* was as follows:

pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Unknown

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? E. B. X-ray sputum, X-ray

(Signed)

2-17-22 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL

Loudon Park

DATE OF BURIAL

Feb 20 1922

20 UNDERTAKER

Firkler &amp; Firkler E. J. F.

ADDRESS

1737 Eager

Physicians should state EXACTLY. PHYSICIANS should be stated EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCASION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61471

CERTIFICATE OF DEATH.

D 61471

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 947 W Lexington ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENT NO. 947 W Lexington ST. (Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life time

How long in U. S., if of foreign birth?

Yrs. Mos. Ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed. Widowed (write the word)

5a If married, widowed or divorced HUSBAND (or) WIFE of Laura M. Curtis

6 DATE OF BIRTH (month, day, and year) July 21 - 1876

7 AGE Years 57 Months 1 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt. Dead weight machine (b) General nature of industry, business, or establishment in which employed (or employee) (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

10 NAME OF FATHER

Patrick Curtis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER

John

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14

Informant Annie Murphy (Address) 947 W. Lexington St.

FEB 19 1922

ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1922, to Feb 17, 1922, that I last saw him alive on Feb 17, 1922, and that death occurred, on the date stated above, at 6 PM.

The CAUSE OF DEATH\* was as follows:

Carcinoma of rectum

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

No

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed) W. B. Friedman, M.D. 612 Columbus Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral

2-20-1922

20 UNDERTAKER

ADDRESS 517 N.

H. B. running Doe

Schneiderst

61472

D 61472

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO., 616 Karoly ST.,                      WARD

(Usual place of abode) \_\_\_\_\_ (If non-resident give city or town and State) \_\_\_\_\_

Length of residence in city or town where death occurred 51 yrs. 11 mos. 0 da. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1922

17  
I HEREBY CERTIFY, That I attended deceased from  
Feb 14, 1911, to Feb 18, 1911

that I last saw him alive on 7/18, 1944.

and that death occurred, on the date stated above, at 928 P m.

The CAUSE OF DEATH\* was as follows:

*Neotoma Mellita*

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY *Debbie Don*  
(Secondary)

(duration) ..... yrs. .... mos. .... ds.

18 Where was disease contracted  
if not at place of death?...

Did an operation precede death? No Date of 11/1/68

Was there an autopsy? .....

What test confirmed diagnosis? Parasitology

(Signed) \_\_\_\_\_, M. D.

19 (Address) 1137 17th St. N.W.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-	DATE OF BURIAL
--------------------------------------	----------------

APPROVAL  
Pocomoke City Ind Feb 19, 1921

NO UNDERTAKER  
John F. Denny

ADDRESS  
715 Light

## HEALTH DEPARTMENT - CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3622 Old York Rd. ST., 9 WARD)

## 2. FULL NAME

Henrietta Craig

(a) RESIDENCE NO.

3622 Old York Rd. ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

FemaleWhiteWidowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

William Craig

6 DATE OF BIRTH (month, day, and year)

Apr. 11 1888

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

835

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Co. Md.

10 NAME OF FATHER

Francis Hardy

11 BIRTHPLACE OF FATHER (city or town)

Md.

(State or country)

12 MAIDEN NAME OF MOTHER

Elizabeth Robinson

13 BIRTHPLACE OF MOTHER (city or town)

Md.

(State or country)

14

Informant

Louise Craig

(Address)

3622 Old York Rd.

15

Filed

19

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 16, 1922, to Feb 18, 1922.that I last saw her alive on Feb 18, 1922.and that death occurred, on the date stated above, at 630 P m.

The CAUSE OF DEATH\* was as follows:

Pneumonia Lobar

(duration)

yrs.

mos. 3

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death? XDid an operation precede death? X Date of XWas there an autopsy? noWhat test confirmed diagnosis? Rusty Sputum(Signed) William Williams, M. D.19 (Address) 601 Carrollton

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOMIAL

Abingdon Md.

20 UNDERTAKER

William Cook

DATE OF BURIAL

4/21 1922

ADDRESS

502 E North,

N. B. - WHERE PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



61474

D 61474

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *725 N. Eutaw*)ST.: *11*

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. *725 N. Eutaw*

(Usual place of abode)

ST..

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *5* yrs. *0* mos. *0* ds.Now long in U. S., if of foreign birth? *0* yrs. *0* mos. *0* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, *hrs.* or *min.*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State, or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

ROBERT H. KRAVITZ

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 18, 1922*

17

HEREBY CERTIFY, That I attended deceased from

*Feb 15, 1922, to Feb 18, 1922*that I last saw him alive on *Feb 17, 1922*and that death occurred, on the date stated above, at *4 a.m.*

The CAUSE OF DEATH\* was as follows:

*Paralysis of Right Hemisphere*(duration) *4* yrs. *0* mos. *0* ds.

CONTRIBUTORY (Secondary)

(duration) *4* yrs. *0* mos. *0* ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *no* Date of *no*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *George L. Duane, M.D.*19 (Address) *725 N. Eutaw St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Laurel Cemetery Feb 20 1922*  
*William Cook 502 E. North St.*

FEB 20 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

# 61475 HEALTH DEPARTMENT—CITY OF BALTIMORE

## 61475 CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred 10 mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Widowed.

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

Widowed.

6 DATE OF BIRTH (month, day, and year)

12/15/1858

7 AGE

63.

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14 Informant (Address)

Mrs. Dunn  
1-1 Rose Ramp Ave.

FEB 20 1922

ROBERT E. KRANTZ  
Registrar

Municipal Health Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

2/18/22

17 I HEREBY CERTIFY, That I attended deceased from

Feb 1, 1922 to Feb 18, 1922

that I last saw him alive on Feb 18, 1922

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cholelithiasis &amp; Cholecystitis

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Feb 9, 1922.

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) D. C. Manning, M. D.

, 19 (Address) St. Joseph's Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Redeemer Cem.

20 UNDERTAKER

George J. Ruth

DATE OF BURIAL

2/20/22

ADDRESS

735 St. Paul.

Physicians should state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

159-002 ✓  
D 61476

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH  
CITY OF BALTIMORE: (No. 1016 Scott)  
2-FULL NAME Mary M. Clark

ST. ... WARD)

(a) RESIDENCE NO. 1016 Dean  
(Usual place of abode)

ST. .... WARD

(If non-resident give city or town and State)

(a) RESIDENT (Usual place of abode)				(b) non-resident (give city or town and state)			
Length of residence in city or town where death occurred	yrs.	mos.	ds.	How long in U. S., if of foreign birth?	yrs.	mos.	ds.

## MEDICAL CERTIFICATE OF DEATH

3 SEX Female	4 COLOR OR RACE White	5 Single, Married, Widowed, or Divorced, (write the word) Single
-----------------	--------------------------	--

16 DATE OF DEATH (month, day, and year) 2-19- 1972

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

17 I HEREBY CERTIFY, That I attended deceased from  
Feb 18, 1922, to Feb 19, 1922.  
that I last saw her alive on Feb 19, 1922.

6 DATE OF BIRTH (month, day, and year) Feb. 18. 1922

and that death occurred, on the date stated above, at 8-9 m.

The CAUSE OF DEATH\* was as follows:

7 AGE	Years	Months	Days	If LESS than 1 day, ....hrs. or ....min.
-------	-------	--------	------	--

### A OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... *None of*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ..... *Balte*  
(State or country) ..... *ind*

10 NAME OF FATHER *John E. Clark*

11 BIRTHPLACE OF FATHER (city or town) Balew  
(State or country) Ind

12 MAIDEN NAME OF MOTHER *Agnes McCaff*

13 BIRTHPLACE OF MOTHER (city or town) Bale,  
(State or country) Ind

14 Informant John E. Clark  
(Address) 1016 Scott St.

15 ROBERT R. KRAUTER,  
FJEB 201322 Burial Permit Clerk, Registrar

Failure of Foramen  
Orate to Close

(duration) yrs. , mos. 2 ds.

CONTRIBUTORY *Premature birth*

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?.....

Did an operation precede death?..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? \_\_\_\_\_

(Signed) Rep. and Dr. J. M. D. M. D.

19 (Address) 127 Columbia St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-	DATE OF BURIAL
--------------------------------------	----------------

MOVABLE  
2/10/22  
ADDRESS

70 UNDERTAKER	ADDRESS
Gas Dynan - Am 1000 Paca	

D 61477 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 E 25th Street ST. 9 WARD)

## 2-FULL NAME

(a) RESIDENCE. NO. 1608 E 25th Street WARD.

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Infant5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant6 DATE OF BIRTH (month, day, and year) Feb 18-19227 AGE Years Months Days If LESS than 1 day, 9 1/2 hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant(b) General nature of industry, business, or establishment in which employed (or employer) Infant(c) Name of employer none9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland10 NAME OF FATHER Louis J. Sheets11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Hettie A. Bowen13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant Mrs Louis J. Sheets (Address) 1608 E 25th Street Balto15 FEB 20 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 19 2217 I HEREBY CERTIFY, That I attended deceased from Feb 18, 19 22, to Feb 18, 19 22that I last saw him alive on Feb 18, 19 22and that death occurred, on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH\* was as follows:

Premature Birth

CONTRIBUTORY (Secondary)

Premature Birth

(duration)

Lived 9 1/2 hrsLived 9 1/2 hrs

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Green M. D.(Address) Hamilton Baltimore Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

WesternFeb 20 19 22

20 UNDERTAKER

ADDRESS

Robert S. Little2700

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.





REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Phy. not sure  
but thought possibly  
cancer of pyloric end  
of stomach.*

61479

## HEALTH DEPARTMENT—CITY OF BALTIMORE 61479

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 N Mulberry ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

(a) RESIDENCE NO. 517 N Mulberry

(Usual place of abode) Length of residence in city or town where death occurred yrs. 6 mos.

ST., WARD

(If non-resident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 19 20

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MOTHER'S NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Herbert Muller 517 N. Mulberry

15 Filed FEB 20 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 10<sup>th</sup> 1922 to Feb 16<sup>th</sup> 1922 that I last saw her alive on Feb 16<sup>th</sup> 1922 and that death occurred, on the date stated above, at 11:00 a. m. The CAUSE OF DEATH\* was as follows: Acute Myocarditis

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 517 N Mulberry (duration) yrs. mos. ds.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Guenger, M. D. 19 (Address) 1002 E. ...

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. See reverse side for additional space.

19 PLACE OF BURIAL, CREMATION OR RE-MOV

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61480

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4408 St George Ave ST. 27 WARD)

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

30 yrs

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male Color

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

56

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

FEB 20 1922

ROBERT R. KRAUTER,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 17 1922

17

I HEREBY CERTIFY, That I attended deceased from December 16 1921 to February 17 1922 that I last saw her alive on February 16 1922 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH\* was as follows:

Apoplexy  
Asthma Dropsy +  
Bright Disease  
(duration) yrs. mos. 2 ds.CONTRIBUTORY Asthma Dropsy +  
Bright Disease  
(Second duration) yrs. 3 mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. W. Kennard M. D.  
2-18-22 Address 708 Enoch St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt. Auburn

20 UNDERTAKER

Daniel Easton

DATE OF BURIAL

Feb 21 1922

ADDRESS

80 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every entry should be made in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61481

## CERTIFICATE OF DEATH.

31 D 61481

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *69 Russell St* ST.: *25* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Clarence Miles*(Residence in Baltimore: No. *69 Russell* St. *25* yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *m* 4-COLOR OR RACE, *Col* 5-SINGLE, *single* MARRIED, WIDOWED, OR DIVORCED, (Write the word.)6-DATE OF BIRTH, *July 13, 1895*  
(Month) (Day) (Year)7-AGE, *26* yrs., *7* mos., *10* ds. If LESS than 1 day, ...hrs. or...min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *none*  
(b) General nature of industry, business, or establishment in which employed (or employer), *add*9-BIRTHPLACE, (State or Country), *Ind*10-NAME OF FATHER, *Adison Miles*11-BIRTHPLACE OF FATHER (State or Country), *Ind*12-MAIDEN NAME OF MOTHER, *Jocener Taylor*13-BIRTHPLACE OF MOTHER (State or Country), *Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Jocener Taylor*(Address) *217 Russell*15- *FEB 20 1922* 191. *ROBERT R. KRAUTER,*

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *2* *17*, *1922*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 3, 1922*, to *July 16, 1922*, that I saw him alive on *2. 16. 22* 1922, and that death occurred, on the date stated above, at m.The CAUSE OF DEATH\* was as follows:  
*Tuberculosis of lungs*(Duration).....yrs. *37* mos. *4* ds.CONTRIBUTORY *chronic insufficiency*  
(Secondary)

(Duration).....yrs. mos. ds.

(Signed) *Wm. B. Hall* M. D.  
*2. 18. 1922* (Address) *Halethorpe*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*Purnace Branch Church* *27 21, 1922*

20-UNDERTAKER ADDRESS

*Mrs. Geo. H. Hoyer 406 W. Maryland*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61482

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(Residence in Baltimore: No.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

## 17- I HEREBY CERTIFY, That I attended deceased from

that I saw h. alive on

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)

(Signed) A. C. S. M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

## 20-UNDERTAKER

## ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

## 4-COLOR OR RACE,

5-SINGLE,  
MARRIED,  
WIDOWER,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

## 7-AGE,

## If LESS than 1 day,

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,  
(State or Country),

## 10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

## 12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

FILED

FEB 20 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

D 61483

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100

D 61483

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2310 Druid Hill Ave. ST. 13 WARD)

## 2-FULL NAME

Nathan Weiner

## (a) RESIDENCE. No.

2310 Druid Hill Ave

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 23 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 6 If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Unknown

## 7 AGE

66

Years

## Months

## Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

086

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Russia

## 10 NAME OF FATHER

Abraham Weiner

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

## 14 Informant

Mat Weiner

(Address)

1805 N. Way St.

## 15

FEB 20 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

2/19

1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb 17, 1922, to Feb 19, 1922

that I last saw him alive on Feb 18, 1922

and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH\* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 10 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed)

Chas. F. Blake

M. D.

Feb 19 1922 Address

20 E. Preston St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Hebrew Rose Dale

Feb 20 1922

## 20 UNDERTAKER

## ADDRESS

Mat Weiner, Balto St

D 61484

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 Roland Heights St. WARD 13)

2-FULL NAME Robert Theodore Brown

(a) RESIDENCE. No. 1009 Roland Heights St. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH

October 17, 1910

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

11

5

0

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Ray Brown

11 BIRTHPLACE OF FATHER (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Mallie George

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant

(Address)

Ray Brown 1009 Roland Heights St.

15

FEB 20 1922

ROBERT N. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, year) February 17, 1922

17 I HEREBY CERTIFY, That I attended deceased from

Dec 9, 1921, to Feb 17, 1922

that I last saw him alive on Feb 17, 1922

and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH\* was as follows:

Ascending Transverse Myelitis

CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. H. M. D.

Address 401 E. 25th St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Green Ridge Cem Feb 20, 1922

20 UNDERTAKER

ADDRESS

Chenoweth &amp; Son, Chestnut St.

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No further history.*

N. B.—WRITE PLAINLY, WITH STANDING CAP—THIS IS A PRELIMINARY RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 6-9-19, W. D. Co.—1000 Bks.

61485

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2716 Huntingdon ave.)

WARD) 17

2-FULL NAME

(a) RESIDENCE. No. 2716 Huntingdon ave.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs.

mos.

ds. How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 24, 1922, to Dec 18, 1922.

that I last saw her alive on Dec 18, 1922.

and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH\* was as follows:

Hypostatic Pneumonia  
Leukemia  
CONTRIBUTORY (Secondary) Neuronal Degeneration  
(duration) yrs. mos. ds.  
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 10

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. A. Richardson, M. D.  
1922 (Address) 112 W. 25th St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Mary Hospital Feb 21, 1922

20 UNDERTAKER

Chenoweth & Son Chataut

FEB 20 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61486

## CERTIFICATE OF DEATH.

117 D 61486

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes' Hospital* ST. WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. *1438 Gough St.* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**White**Widowed*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Edwin H. Jones*

6 DATE OF BIRTH (month, day, and year)

*Unknown*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*4 years*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Housework*9 BIRTHPLACE (city or town)  
(State or country)*Baltimore Md*

10 NAME OF FATHER

*do not know*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

*Mally Quency*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*do not know*

14

Informant

(Address)

*Mrs. Mally Quency**311 S. Broadway*

15

ROBERT A. KRAUTER,

Burial Permit Clerk.

FEB 20 1922

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb 18 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 27, 1922, to Feb 18, 1922*

that I last saw her alive on

*Feb 18, 1922*

and that death occurred, on the date stated above, at

*8:10 a.m.*

The CAUSE OF DEATH\* was as follows:

*Appendix Abscess - Peritonitis  
Bacterial Intestines -  
High fecal fistula*CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?*Home*

Did an operation precede death?

*Yes Date of Jan. 1922*

Was there an autopsy?

*Yes*

What test confirmed diagnosis?

*Op -*

(Signed)

M. D.

19 (Address)

*W. Caldwell, M.D.  
St. Agnes' Hospital*

\*State the Disease Causing Death, or in deaths from violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL

20 UNDERTAKER

ADDRESS

*M. Oliver, Bur.**Feb 21 1922**Geo M. Smith, Son**811 N. Wolfe*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61487 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 D 61487

CERTIFICATE OF DEATH.

PLACE OF DEATH  
CITY OF BALTIMORE (No. 318 S. Bouldin ST. 76 WARD)  
2-FULL NAME Wm. J. Baker  
(Residence in Baltimore: No. 318 S. Bouldin

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 70 - 1 - 29 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed  
6-DATE OF BIRTH December 18, 1951 (Month) (Day) (Year)  
7-AGE, 70 yrs. 1 mos. 29 ds. If LESS than 1 day, hrs. or min.  
8-OCCUPATION: (a) Trade, profession, or particular kind of work Laborer (b) General nature of industry, business, or establishment in which employed (or employer) 040  
9-BIRTHPLACE, (State or Country), Balto. Md.  
PARENTS.  
10-NAME OF FATHER, Henry Baker  
11-BIRTHPLACE OF FATHER (State or Country), Germany  
12-MAIDEN NAME OF MOTHER, Unknown  
13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) Sophia Legeder  
(Address) 318 S. Bouldin St.

15- FEB 20 1922

ROBERT R. KRAUTER,

191- Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 17, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy, or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular heart disease (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) Shessey Syau M. D. (Coroner) 2/19/22 (Address) 1800 N. Charles St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Trinity Cem. Feb. 20, 1922

20-UNDERTAKER, ADDRESS 2016

Philip Herwig Orleans St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61488

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 900 W. Lombard St. ST. 3 WARD)

2-FULL NAME Francis A. Stewart

(a) RESIDENCE. NO. 900 W. Lombard St. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 4 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male. 4 COLOR OR RACE white. 5 Single, Married, Widowed, or Divorced (write the word) married.

5a If married, widowed, or divorced HUSBAND of Emma F. Burns Stewart (or) WIFE of

6 DATE OF BIRTH (month, day, and year) SEPT. 26-1851

7 AGE Years 70 Months 4 Days 23. If LESS than 1 day. hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired driver.

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

10 NAME OF FATHER Francis A. Stewart

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md. (State or country)

12 MAIDEN NAME OF MOTHER Emeline Frozzell

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md. (State or country)

14 Informant Mrs. Emma F. Stewart (Address) 900 W. Lombard St.

15 FEB 20 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/18/22 19

17 I HEREBY CERTIFY, That I attended deceased from 1/12/22 to 2/18/22, 19

that I last saw him alive on 2/18/22, 19

and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH\* was as follows:

Chr. Diff. Nephritis

(duration) 2 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? heart

(Signed) J. M. D.

15/22 (Address) 910 W. Lombard

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Port Cemetery Feb 21 1922

20 UNDERTAKER ADDRESS

J. J. Cowan 901 Hollister

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

*Edw Thomas*  
HEALTH DEPARTMENT—CITY OF BALTIMORE *4-001*  
D 61489  
CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2127 Division*)ST. *14* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Edw Thomas*(a) RESIDENCE. No. *2127 Division*

(Usual place of abode)

ST. \_\_\_\_\_ WARD \_\_\_\_\_

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*black*

5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Single*

6 DATE OF BIRTH (month, day, and year)

*Feb 27 1892*

7 AGE

*39*

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer 040*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Thomas Gray*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore*

10 NAME OF FATHER

*Edward Thomas*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*md*

12 MAIDEN NAME OF MOTHER

*Ann Gray*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*md*

14

Informant (Address)

*Edw Thomas 2127 Division*

15

Filed

FEB 20 1922 ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/27* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

*2/15* 19*22* to *2/17* 19*22*that I last saw him alive on *2/17* 19*22*and that death occurred, on the date stated above, at *5:30* p.m.

The CAUSE OF DEATH\* was as follows

*Cerebral Apoplexy & Paralysis*

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of \_\_\_\_\_Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Buglitta*, M. D., 19 (Address) *2127 Division*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*mt cemetery**Feb 20 1922*

20 UNDERTAKER

ADDRESS

*Edward King 403 E. 33*

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61490

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1649 Abbott ST.: 7 WARD)

## 2-FULL NAME

Elizabeth Courtney

## (a) RESIDENCE. NO.

1649 Abbott

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

Edward Courtney6 DATE OF BIRTH (month, day, and year) Nov, 18827 AGE Years 34 Months 3 Days 3 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work.

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Penna.

10 NAME OF FATHER

George Tillman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Emma Norwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

New Jersey

## 14

Informant (Address)

Annie Siler  
1200 N. Milton Ave

## 15

Filed

FEB 20 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18/2217 I HEREBY CERTIFY, That I attended deceased from Feb 18/22, 1922, to Feb 18, 1922, that I last saw her alive on Feb 18, 1922, and that death occurred, on the date stated above, at 9.45 a. m.The CAUSE OF DEATH\* was as follows:  
Chronic Interstitial Nephritis  
(From history of case)CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 4 yrs. mos. ds.18 Where was disease contracted if not at place of death? Place of deathDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Manual clinical(Signed) W. D. McDonald M. D.(Address) 1540 N 13 Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Carmel Cemetery 2/20 1922

20 UNDERTAKER ADDRESS

John A. Moran 3000 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

61491

129 D 61491

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Lathrop Apartment*)ST. *11* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Faris Chappell Pitt,*(a) RESIDENCE. No. *Lathrop Apartment*

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*

5a If married, widowed, or divorced

HUSBAND *Nettie G. Wood.*6 DATE OF BIRTH (month, day, and year) *Mar 1, 1842*7 AGE Years Months Days *79 11 17* If LESS than 1 day, 1 hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Art Dealer.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore,*

(State or country)

10 NAME OF FATHER *Charles Faris Pitt.*11 BIRTHPLACE OF FATHER (city or town) *Baltimore.*

(State or country)

12 MAIDEN NAME OF MOTHER *Catharine Chappell.*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore.*

(State or country)

14 Informant *Herbert H. Pitt.*(Address) *912 N. Charles St. Baltimore, Md.*

15 FEB 20 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 18 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Oct 13, 1918, to Feb 18, 1922,*that I last saw him alive on *Feb 17, 1922,*and that death occurred, on the date stated above, at *1:45 P. M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Interstitial Nephritis.**Hypertrophied Prostate & Cystitis*(duration) *3 1/2* yrs. mos. ds.CONTRIBUTORY *Nephritis, Hypertrophied Prostate*

(Secondary)

*Infirmities of age* (duration) *5 1/2* yrs. } mos. ds.18 Where was disease contracted *Unknown*

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical & Chemical*(Signed) *A. C. Carman*, M. D.2-18-1922 (Address) *1701 N. Caroline*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Resurrection Cemetery Feb 20 1922*

## 20 UNDERTAKER

## ADDRESS

*Henry Jenkins & Sons Co**1001 N. Carroll St.*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.





15-3903  
N. E.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

61493

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7)

WARD

2-FULL NAME

Anna M. Steele

(a) RESIDENCE. No.

Port Deposit

WARD

Maryland.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. 1 mos. 7 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

William Steel

6 DATE OF BIRTH (month, day, and year)

July 17-1862

7 AGE

Years

Months

Days

If LESS than 1 day, .... hrs. or .... min.

59

6

22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Wm. Whitelock

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Delaware

12 MAIDEN NAME OF MOTHER

Jane Weston

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Delaware

14

Informant (Address)

JOHNS HOPKINS HOSPITAL  
Records

15

Filed

FEB 20 1922

ROBERT R. KRAUTER  
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1922

17 I HEREBY CERTIFY. That I attended deceased from Feb. 16, 1922, to Feb. 18, 1922, that I last saw h. alive on Feb. 18, 1922, and that death occurred, on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH\* was as follows:

Raynaud's disease

(duration) 2 yrs. 6 mos. 0 ds.

CONTRIBUTORY Broncho-pneumonia Acute (Secondary) Endocarditis (duration) 0 yrs. 5 mos. 5 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) C. Sidney Murray, M. D.

, 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Port Deposit Md.

DATE OF BURIAL

Feb 21 1922

20 UNDERTAKER

Henry J. Jenkins Sons

ADDRESS

McCulloch Orchard

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61494

## CERTIFICATE OF DEATH.

46 D 61494

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1927 Harlem St. ST. 16 WARD)

### 2-FULL NAME

Annie M. Shirley

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### (a) RESIDENCE NO.

1927 Harlem St. ST. 16 WARD

(Usual place of abode)

### (b) RESIDENCE NO.

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. H. Shirley

6 DATE OF BIRTH (month, day, and year) Nov-16-1884

7 AGE Years 37 Months 3 Days 1 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Zevel. Goslin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Luscm. Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Webster Prosser (Address) 1927 Harlem St.

15 FEB 20 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 9th 1921 to Feb 17th 1921, that I last saw her alive on Feb 17th 1921, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH\* was as follows: Inoperable Carcinoma Cervix uteri general Metastases

(duration) 2 yrs. 2 mos. 2 ds.

CONTRIBUTORY Tuberculosis (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ray. A. McElroy M. D. 18 1921 (Address) 400 N. Payson St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE Calvary Bldg DATE OF BURIAL Feb 20 1922

20 UNDERTAKER W. L. Lichman & Son ADDRESS North Kima

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1990 Bks.

*Lawrence Neuschaefer*  
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61495

CERTIFICATE OF DEATH.

131

REGISTERED NO. *61495*  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH *Munroe Corp*  
CITY OF BALTIMORE: NO *LAWRENCE NEUSCHAEFER* ST. *2* WARD)

2-FULL NAME *Lawrence Neuschaefer*

(a) RESIDENCE. NO. *600 North 8. Belle* ST. *2* WARD.  
(Usual place of abode)  
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <i>M</i>	4 COLOR OR RACE <i>W</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Single</i>	
5a If married, widowed, or divorced HUSBAND of (or) WIFE of			
6 DATE OF BIRTH (month, day, and year) <i>1867</i>			
7 AGE <i>54</i>	Years	Months	Days If LESS than 1 day, hrs. or min.
8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work <i>Laborer</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>64</i> (c) Name of employer			
9 BIRTHPLACE (city or town) (State or country) <i>Balto. Md.</i>			
10 NAME OF FATHER <i>Lawrence Neuschaefer</i>			
11 BIRTHPLACE OF FATHER (city or town) (State or country) <i>Germany</i>			
12 MAIDEN NAME OF MOTHER <i>Christina Honey</i>			
13 BIRTHPLACE OF MOTHER (city or town) (State or country) <i>Balto. Md.</i>			

14 Informant *Ray Reed*  
(Address)

15 *FEB 20 1922*  
ROBERT R. KRAUTER,  
Special Permit Clerk.

MEDICAL CERTIFICATE OF DEATH	
16 DATE OF DEATH (month, day, and year) <i>2-17-22</i>	
17 I HEREBY CERTIFY, That I attended deceased from <i>2-16-22</i> to <i>2-17-22</i> , 19 <i>22</i> that I last saw him alive on <i>2-17-22</i> and that death occurred, on the date stated above, at <i>11:05 A.M.</i> The CAUSE OF DEATH* was as follows: <i>Pylonephritis</i> <i>Uremia</i> (duration) yrs. <i>1</i> mos. <i>7</i> ds. CONTRIBUTORY (Secondary) (duration) yrs. <i>7</i> mos. <i>7</i> ds. 18 Where was disease contracted If not at place of death? Did an operation precede death? Date of Was there an autopsy? <i>Yes</i> What test confirmed diagnosis? (Signed) <i>Clifford M. Neill</i> M. D. <i>Munroe Corp</i> -1697 Address	
*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)	

19 PLACE OF BURIAL, CREMATION OR REMOVAL. *Holy Redeemer Cem* DATE OF BURIAL *Feb 20 1922*

20 UNDERTAKER *Lilly Zeiler* ADDRESS *4008 North 16*



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61496

D 61496

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (Name of street and house or apartment number) 812 N. Linwood Ave. (WARD)

### 2-FULL NAME

(a) RESIDENCE NO. 812 N. Linwood Ave. WARD

(Usual place of abode) Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2, 1872

7 AGE 50 yrs. Years Months Days If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Meter Inspector (b) General nature of industry, business, or establishment in which employed (or employer) State Department (c) Name of employer

9 BIRTHPLACE (city or town, State or country) Baltimore, Md.

10 NAME OF FATHER William Diver

11 BIRTHPLACE OF FATHER (city or town, State or country) Philadelphia, Pa.

12 MAIDEN NAME OF MOTHER Mary E. Johnson

13 BIRTHPLACE OF MOTHER (city or town, State or country) New Jersey

14 Informant (Address) Mrs. Elizabeth Diver 812 N. Linwood Ave.

15 Filed 1922

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19, 1922

17 I HEREBY CERTIFY That I attended deceased from December 1, 1921 to February 1, 1922 that I last saw him alive on February 1, 1922 and that death occurred, on the date stated above, at 5:15 a.m.

The CAUSE OF DEATH was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted (If not at place of death?)

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Broadway, M.D. (Address) 6 North Street

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT DATE OF BURIAL

20 UNDERTAKER ADDRESS

Woodward & Lothrop 11 Front St. Baltimore, Md. William back 502 E. North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bka.

D 61497

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 325 S. Robinson

ST. WARD)

2-FULL NAME Mary E. Leman

(a) RESIDENCE No. 325 S. Robinson

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 20 1864

7 AGE 57 Years 1 Months 28 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER Valentine Dearing

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Walter V. Leman (Address) 325 S. Robinson St

15 Registrar E. J. Fanning

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/18/ 19 22

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 19 22, to Feb 18, 19 22, that I last saw her alive on Feb 17, 19 22, and that death occurred, on the date stated above, at 4 A. m. The CAUSE OF DEATH\* was as follows: Apoplexy

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. A. M. M. D. Feb 19 22 Address 100 S. Patterson Park Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Baltimore Cemetery

Feb 20 19 22

20 UNDERTAKER

ADDRESS

E. J. Fanning & Son - 1438 E. Lafayette Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1900 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61498

## CERTIFICATE OF DEATH

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 927 United Hill av

ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

Mr. Bacon

### (a) RESIDENCE. NO.

927 United Hill

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

25 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

#### 3 SEX

M

#### 4 COLOR OR RACE

Blk

#### 5 Single, Married, Widowed, or Divorced (write the word)

married

#### 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary Bacon

#### 6 DATE OF BIRTH (month, day, and year)

unknown

#### 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

93

#### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

god

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

#### 9 BIRTHPLACE (city or town) (State or country)

Glencott City Md

#### 10 NAME OF FATHER

unknown

#### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

#### 12 MAIDEN NAME OF MOTHER

unknown

#### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

#### 14

Informant (Address)

Mrs Mary Bacon 927 United Hill

#### 15

Filed

FEB 20 1922

J. E. Wehn

Registrar

### MEDICAL CERTIFICATE OF DEATH

#### 16 DATE OF DEATH (month, day, and year)

Feb 16

1922

#### 17

I HEREBY CERTIFY, That I attended deceased from

May 17, 1921 to Feb 16, 1922 that I last saw him alive on Feb 15, 1922.

and that death occurred, on the date stated above, at 1:20 P. M.

The CAUSE OF DEATH\* was as follows:

Mitral Regurgitation

(duration)

yrs.

mos.

ds.

#### CONTRIBUTORY (Secondary)

Arterio Sclerosis

(duration)

yrs.

mos.

ds.

#### 18 Where was disease contracted if not at place of death?

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed)

Justin Goldman

M. D.

19 (Address)

230 N. Front St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

#### 19 PLACE OF BURIAL, CREMATION OR REMOVAL

#### DATE OF BURIAL

London Park & S. National

Feb 20 1922

#### 20 UNDERTAKER

#### ADDRESS

H. Maurice Routson

230 N. Front

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 61499

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61499

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

FEB 20 1922

St. Wehm

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Jan 10, 1922, to Feb. 19, 1922, that I last saw him alive on Feb. 19, 1922.

and that death occurred, on the date stated above, at 12:10 P. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Stomach

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Thrombosis

(duration) yrs. 24 mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

61500

## CERTIFICATE OF DEATH

38

61500

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 516 S. Montford Ave ST. 1 WARD)

2-FULL NAME George M. Mika

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 516 S. Montford Ave

Sr.: 29 yrs. 10 mos. 6 ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6-DATE OF BIRTH April 22, 1893  
(Month) (Day) (Year)

7-AGE 29 yrs. 10 mos. 6 ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Copper works at Canton. (b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE (State or country) Baltimore, Md.

10-NAME OF FATHER John Mika

11-BIRTHPLACE OF FATHER (State or country) Poland

12-MAIDEN NAME OF MOTHER Anna Bogdan

13-BIRTHPLACE OF MOTHER (State or country) Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna Mika (Mother)

(Address) 516 S. Montford Ave

15- FEB 20 1922 ROBERT R. KRAUTER,  
Filed Burial Permit Registrar

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH February 18, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1st, 1921, to Feb. 18, 1922 that I saw him alive on February 18, 1922 and that death occurred, on the date stated above, at 1 P. m. The CAUSE OF DEATH\* was as follows:

Angina Pectoris

(Duration) 1 yrs. 1 mos. 18 ds.  
Contributory Pulmonary Emphysema  
(SECONDARY)

(Signed) M. Abramson M. D. Feb. 19, 1922 (Address) 1707 E. Baltimore

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL St. Stanislaus Cem. DATE OF BURIAL Feb 22, 1922

20-UNDERTAKER M. F. Sadowski ADDRESS 405 S. Ann St

*Luetic in origin. Case reported in Lab. under name of Geo. Mick.*

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*,

*meninges, peritoneum, etc.*, *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" merely symptomatic, "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

<i>Abortion,</i>	<i>Haemorrhage,</i>	<i>Meningitis,</i>	<i>Phlebitis,</i>
<i>Cellulitis,</i>	<i>Gangrene,</i>	<i>Miscarriage,</i>	<i>Pyæmia,</i>
<i>Childbirth,</i>	<i>Gastritis,</i>	<i>Necrosis,</i>	<i>Septicæmia,</i>
<i>Convulsions,</i>	<i>Erysipelas,</i>	<i>Peritonitis,</i>	<i>Tetanus,</i>

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved): *Suicides*, *Homicides*, *Abortions (if induced)*, whether death is directly or indirectly due to the same.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61501

## CERTIFICATE OF DEATH.

D 61501

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12059 Laurel ST.: 16 WARD)

2-FULL NAME

(a) RESIDENCE. No. 12059 Laurel ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 10 mos. 10 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

6 DATE OF BIRTH (month, day, and year) Feb 8, 1867

7 AGE 50 Years 10 Months 10 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

10 NAME OF FATHER J. H. Carey

11 BIRTHPLACE OF FATHER (city or town) Ireland

12 MAIDEN NAME OF MOTHER A. E. Lyons

13 BIRTHPLACE OF MOTHER (city or town) Ireland

14

Informant (Address) 4145 Madison Ave

15

FEB 20 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 16th 1922, to Feb 18th 1922 that I last saw her alive on Feb 18th 1922.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary) (duration) yrs. mos. 6 ds. pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 12059 Laurel St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. B. Evans, M. D.

19 (Address) 411 N. Greene St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral

DATE OF BURIAL

2-21-1922

20 UNDERTAKER

W. Branningham

ADDRESS 717A

Schroeder

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 61502

31

D 61502

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

St.; yrs.. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

Nov. 15, 1889

7-AGE,

68

3

mos.

4

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

Stone 075

Cutter

9-BIRTHPLACE, (State or Country),

Balt. Md.

10-NAME OF FATHER,

Joseph H. Minnick

11-BIRTHPLACE OF FATHER (State or Country),

Balt

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Balt Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Harry Minnick

(Address)

1813 Hape St

15-

FEB 20 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan

19

1916

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I am in charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

...and that said deceased came to death

(Inquest, au-

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Asthma Presumably

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Coroner)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

In the

of death... yrs. .... mos. .... ds. State... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Catholic Cemetery

DATE OF BURIAL,

Feb. 22, 1922

20-UNDERTAKER

George J. Ruth

ADDRESS

1735 Hape St



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 61503

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 61503

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1430 Linden Avenue ST.; 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Kemp

(a) RESIDENCE. NO. 1430 Linden Avenue ST., WARD.  
(Usual place of abode)

Length of residence in city or town where death occurred 86 yrs. 5 mos. 25 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard C. Kemp

6 DATE OF BIRTH (month, day, and year) Aug. 23, 1835

7 AGE Years 86 Months 5 Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER William F. Adam

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Coe

13 BIRTHPLACE OF MOTHER (city or town) U. S. A. (State or country)

14 Informant Richard V. Kemp (Address) 3042 Guilford Avenue

15 Filed Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18, 1922

17 I HEREBY CERTIFY. That I attended deceased from Sept. 7, 1922, to Sept. 18, 1922, that I last saw her alive on Sept. 18, 1922, and that death occurred, on the date stated above, at 9.45 a. m. The CAUSE OF DEATH\* was as follows:

General Arteriosclerosis  
(duration) 7 yrs. mos. ds.  
CONTRIBUTORY Cardiac failure  
(Secondary) (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? (Signed) Wm. J. Kelly, M. D.

7/20, 1922 (Address) 701 N. Kenwood Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery DATE OF BURIAL 2/21 1922

20 UNDERTAKER Henry W. Mears & Son 805 N. Calvert ADDRESS

EB 20 1922

Burial Permit Clerk.

D 61504

HEALTH DEPARTMENT—CITY OF BALTIMORE, 091 61504

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 Granby ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1011 Granby St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female  
4-COLOR OR RACE, White  
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)

## 6-DATE OF BIRTH,

Feb 19, 1912  
(Month) (Day) (Year)

## 7-AGE,

yrs. mos. ds. If LESS than 1 day, 7 hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Clerk  
(b) General nature of industry, business, or establishment in which employed (or employer), 800

## 9-BIRTHPLACE, (State or Country),

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER (State or Country),

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER (State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joe Palucco

(Address) 1011 Granby St.

## 15-

Robert P. Harrison,

Filed

191

Registrar.

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Feb 20, 1912  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from Feb 19, 1912, to Feb 20, 1912,

that I saw her alive on Feb 19, 1912,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. A. Harrison, M. D.

Feb 20, 1912 (Address) 3115 E. 19th St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

St. Vincent's Cem.

## DATE OF BURIAL,

Feb 21, 1912

## 20-UNDERTAKER,

Lilly &amp; Ziehl

## ADDRESS

403 S. Wolfe St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

D 61505 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 D 61505  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5522 York Rd ST.; 27th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. H. Wooden

(Residence in Baltimore: No. 5522 York Rd. St.; 69 yrs., 5 mos. 17 ds)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)

6-DATE OF BIRTH, August 3, 1852 (Month) (Day) (Year)

7-AGE, 69 yrs., 5 mos., 17 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Retired (b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Balt Co., Md.

10-NAME OF FATHER, William H. Wooden

11-BIRTHPLACE OF FATHER (State or Country), Balt Co.

12-MAIDEN NAME OF MOTHER, Elizabeth

13-BIRTHPLACE OF MOTHER (State or Country), Balt Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Matka Wooden

(Address), 5522 York Rd.

15-

Robert E. Harrison,

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 19, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 5, 1922, to February 19, 1922, that I saw him alive on February 18, 1922, and that death occurred, on the date stated above, at 11:15 P. m. The CAUSE OF DEATH\* was as follows:

Chronic End. Nephritis (Duration), 10 yrs., mos., ds.

CONTRIBUTORY, T. H. Harrison (Secondary) (Duration), yrs., mos., ds.

(Signed) George W. T. Bishop, M. D. Feb. 19, 1922 (Address), 501 S. Street

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAVELERS, OR RECENT RESIDENTS).

At place of death 1 yrs., mos., ds. In the State 69 yrs., 5 mos., 17 ds.

Where was disease contracted, 1917 E. Preston St. if not at place of death?

Former or usual residence 1917 E. Preston St.

19-PLACE OF BURIAL OR REMOVAL, Bakers Family DATE OF BURIAL, Feb. 22, 1922

20-UNDERTAKER, Williams Cook ADDRESS, 502 E. North St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

B 201922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61506

CERTIFICATE OF DEATH.

D 61506

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 N. Park

ST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Edward W. Bogy

(a) RESIDENCE. NO.

119 N. Park

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb. 9, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 18, 1922, to Feb 19, 1922, that I last saw him alive on Feb 17, 1922,

and that death occurred, on the date stated above, at 12 P. M.

The CAUSE OF DEATH\* was as follows:

Brain trouble, pneumonia with other virus infection.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. R. M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park

DATE OF BURIAL

Feb 21, 1922

20 UNDERTAKER

Jerkent Jerkner

ADDRESS

734 Eager

EB 201922

Marial Permit Clerk.



WHITE PRINTED, WITH GREEN INK—THIS IS A PRELIMINARY RECORD.  
B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61507 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61507  
CERTIFICATE OF DEATH.

1-PLACE OF DEATH  
City of BALTIMORE: (No. 2427 Georgetown Rd St. 25 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
2-FULL NAME George E. Kemp  
(Residence in Baltimore: No. 2427 Georgetown Rd St.; yrs. .... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <u>Male</u>	4-COLOR OR RACE, <u>White</u>	5-Single, Married, Widowed, or Divorced, (Write the word.) <u>Single</u>
6-DATE OF BIRTH, <u>Aug</u> <u>29</u> 19 <u>24</u> (Month) (Day) (Year)		
7-AGE, yrs. <u>5'</u> mos. <u>21</u> ds.		If LESS than 1 day, ... hrs. or ... min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <u>none job</u>		
9-BIRTHPLACE, (State or Country), <u>Bald m d</u>		
PARENTS.	10-NAME OF FATHER,	<u>Charles Kemp</u>
	11-BIRTHPLACE OF FATHER, (State or Country),	<u>Bald Co.</u>
	12-MAIDEN NAME OF MOTHER,	<u>Mary Henrich</u>
	13-BIRTHPLACE OF MOTHER, (State or Country),	<u>Bald Co.</u>

11-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) Charles Kemp  
(Address) 2427 Georgetown Rd

15-  
Filed Feb 20 1925 1022 Robert F. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 19 1925  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said Inquest, and that said deceased came to his death on the day stated above.  
The CAUSE OF DEATH was as follows:  
Acute Gastric Cancer

(Duration) yrs. .... mos. 4 ds.  
CONTRIBUTORY Cerebral  
(Secondary) (Duration) yrs. .... mos. 7 ds.  
(Signed) J. M. P. Norton M. D.  
(Coroner)  
Feb 19 1925 (Address) 700 E. Chase St

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).  
At place of death, yrs. .... mos. .... ds. In the State, yrs. .... mos. .... ds.  
Where was disease contracted, if not at place of death?

Former or usual residence  
19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,  
London Park Feb 24 25  
20-UNDERTAKER, ADDRESS  
E. W. Dill Frederick Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Hks.

D 61508

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61508

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Balt. Eye + Ear + Throat Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 625 W. Franklin St. ST.: 25 WARD)

2-FULL NAME MRS. ANNIE HUBER

(a) RESIDENCE. No. New Annex, Curtis Bay, Md. ST. Government Station

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 2 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Huber

6 DATE OF BIRTH (month, day, and year) Dec. 9, 1878

7 AGE Years 43 Months 2 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

10 NAME OF FATHER John Hloyle

11 BIRTHPLACE OF FATHER (city or town) Ireland. (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Ireland. (State or country)

14 Informant Jacob Huber (Address) Curtis Bay.

15 Filed Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1922, to Feb. 19, 1922.

that I last saw her alive on Feb. 18, 1922.

and that death occurred, on the date stated above, at 2:30 A. M.

The CAUSE OF DEATH\* was as follows:

Cerebral spinal Meningitis over

(duration) yrs. mos. 6 ds.

CONTRIBUTORY Chronic Junctional Stutter Medium (Secondary)

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? New Annex, Curtis Bay

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam. of spinal fluid.

(Signed) W. K. Fisher M. D.

, 19 (Address) 575 Cathedral St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral Cem. Feb. 21, 1922

20 UNDERTAKER ADDRESS

Margaret S. Flynn 1422 High St.

FEB 20 1922

Burial Permit Clerk

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inunction," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Nonepidemic Meningitis  
secondary to otitis  
media. No infection  
prior to otitis media  
as far as phy. could  
determine.*

D 61509

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 N. Port. ST. 7 WARD)

## 2-FULL NAME William Besvejeck

(a) RESIDENCE. No. 715 N. Port.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year)

April 28, 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

9 21

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Benjamin Surjeck

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Ella Bartol

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

Benjamin Surjeck 715 N. Port St

Robert F. Harrison,

19

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 19, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 17, 1922, to Feb 17, 1922.

that I last saw him alive on

Feb 17, 1922.

and that death occurred, on the date stated above, at

11 p.m.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Harry Boyd, M. D.

2524 19 22 Address

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oak Hill Cemetery

Feb 21, 1922

20 UNDERTAKER

ADDRESS

Elmer W. Boucklin 24 E. Engle

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of UPA-TION is very important. See instructions on back of certificates.

FEB 20 1922



# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61510

D 61510

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE

2-FULL NAME

(a) RESIDENCE

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

201922 Robert F. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Myocardial Infarction

CONTAGIOUS (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. McManis, M. D.

, 19 (Address) St. Joseph's Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*(Bonanno)*  
**HEALTH DEPARTMENT—CITY OF BALTIMORE** *DB 61511*

D 61511

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1124 Proctor* ST.: *10* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

*Giuseppe Bonanno*

(a) RESIDENCE. NO.

*1124 Proctor*

ST.

WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred *15* yrs. mos. ds. How long in U. S., if of foreign birth? *15* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Jan. 31-1922*7 AGE *38* Years *1* Months *16* Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Labor 040*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Italy*

10 NAME OF FATHER

*Pietro Bonanno*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Italy*

12 MAIDEN NAME OF MOTHER

*Maria Terini*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Italy*

14 Informant (Address)

*Carmelo La Paglia 1124 Proctor St.*

15 Filed

*Robert P. Harrison, Registrar*

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 18* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 4*, 19*22*, to *Feb 18*, 19*22*.that I last saw him alive on *Feb 18*, 19*22*.and that death occurred, on the date stated above, at *6 P.* m.

The CAUSE OF DEATH\* was as follows:

*Brudis - Pneumonia*(duration) yrs. mos. *15* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *1* ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *no*(Signed) *Wm. J. Delaney* M. D.Address *1038 Broadway*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St Vincent's Cemetery**2/21* 19*22*

20 UNDERTAKER

ADDRESS

*George J. Ruth**1736 Harford Ave*

INFORM. B. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

FEB. 20 1922

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61512 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61512

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 2023 Md Ave 12 Ward  
City of BALTIMORE: (No. 12 St. 12 Ward)  
2-FULL NAME John W. Free  
(Residence in Baltimore: No. 2022 Md. Ave St.; yrs. Life mos. ds.)

Registered No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M. 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced, Single  
6-DATE OF BIRTH, Apr 28 1881  
7-AGE, 40 yrs. 4 mos. 22 ds. If LESS than 1 day, hrs. or min.?  
8-OCCUPATION: (a) Trade, profession, or particular kind of work, Clerk (b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Balt.

10-NAME OF FATHER, Hiram W. Free  
11-BIRTHPLACE OF FATHER, Ill.  
12-MAIDEN NAME OF MOTHER, Mary M. Grice  
13-BIRTHPLACE OF MOTHER, Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. C. Harrison  
(Address) 2034 Huntington Ave

15-

Robert P. Harrison,

Titled

192

Registrar.

Serial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 20 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to death by topsy or inquiry on the day stated above.

THE CAUSE OF DEATH as follows:  
Gun shot wound in head  
Suicide

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.  
(Signature) J. P. Harrison D. (Coroner.)  
1922 (Address) 1632 Roland

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Lowdown Park

Feb. 21 1922

20-UNDERTAKER,

ADDRESS

J. M. Cook

205 E. McC-

FEB 20 1922

S. A. F. T. Y. A

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 61513

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61513

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 E Hughes ST., 22 WARD)

2. FULL NAME

Bertie T. Couch

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

117 E Hughes

ST., 22 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Couch

6 DATE OF BIRTH (month, day, and year) April 24/1904

7 AGE Years 17 Months 9 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

10 NAME OF FATHER

May C. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER

White Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14

Informant (Address)

May C. Smith

15

Filed

Robert T. Harrison

19

Registrar

Bertie T. Harrison

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1922 to Feb 19, 1922, that I last saw her alive on Feb 19, 1922, and that death occurred, on the date stated above, at 320 m.

The CAUSE OF DEATH\* was as follows:  
Myocardial insufficiency  
Dilatation heart

CONTRIBUTORY (Secondary) Pulmonary edema (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Auscultation

(Signed) J. H. O'Donnell M. D.

(Address) 1025 West St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Calvin

20 UNDERTAKER

Wm. Cook

DATE OF BURIAL

Feb. 19 1922

ADDRESS

W & M



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61514

HEALTH DEPARTMENT—CITY OF BALTIMORE

old D 61514

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3906 1/2 Lloyd Ave St. 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Joseph H. Barker  
(Residence in Baltimore: No. 3906 1/2 Lloyd Ave St.; yrs. 70 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male  
4-COLOR OR RACE, white  
5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH, 1852  
(Month) (Day) (Year)

7-AGE, 70 yrs. mos. ds.  
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), D.C. Md.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country), "

12-MAIDEN NAME OF MOTHER, "

13-BIRTHPLACE OF MOTHER, (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Sarah J. Schaper  
(Address) 3906 1/2 Lloyd St

15-Report P. Harrison, Registrar.  
Filed 1922 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 19, 1922  
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
Cerebral hemorrhage  
(Duration) yrs. mos. ds. 1 ds.  
CONTRIBUTORY (Secondary) no history  
(Duration) yrs. mos. ds.  
(Signed) J. J. Hennessy, M. D. (Coroner.)  
Feb. 19, 1922 (Address) 2802 Edmondson Ave.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).  
At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

Woodlawn Feb. 21, 1922

20-UNDERTAKER, ADDRESS

Wm Cook, 502 E North Ave.

Feb 20 1922

For Hennessy 2802 Edmondson Ave.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

NOTE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61515 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61515

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Mercy Hospital*  
City of BALTIMORE: (No. *90* St. *Ward* (If death occurred in a Hospital or Institution, give its NAME instead of street and number and fill out No. 18.)  
2-FULL NAME *Edmund J. Smith*  
(Residence in Baltimore: No. *800 Homestead St.* 411 St.; yrs. .... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *M* 4-COLOR OR RACE *White* 5-Single, Married, Widowed, or Divorced. (Write the word.) *Married*  
6-DATE OF BIRTH *not known*  
7-AGE *63* If LESS than 1 day, .... hrs. or .... min.?  
8-OCCUPATION: (a) Trade, profession, or kind of work *Rubber worker* (b) General nature of industry, business, or establishment in which employed (or employer) *086*  
9-BIRTHPLACE, (State or Country), *England*  
10-NAME OF FATHER, *Ed J. Jenkins*  
11-BIRTHPLACE OF FATHER, (State or Country), *England*  
12-MAIDEN NAME OF MOTHER, *not known*  
13-BIRTHPLACE OF MOTHER, (State or Country), *England*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) *Low, William*  
(Address) *800 Homestead St.*

15- Robert P. Harrison, Registrar.  
1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *Feb 18 1922*  
(Month) (Day) (Year)  
17- I HEREBY CERTIFY, that I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.  
The CAUSE OF DEATH was as follows:  
*acute*  
*Pneumonia*  
*Ordinary*  
*45m*  
CONTRIBUTORY (Secondary) *Asphyxia*  
(Duration) yrs. .... mos. .... ds.  
(Signed) *G. C. Smith* M. D.  
(Coroner.)  
(Address) *112 N. Bond*  
\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).  
At place of death. .... yrs. .... mos. .... ds. In the State. .... yrs. .... mos. .... ds.  
Where was disease contracted, if not at place of death? .....

Former or usual residence. ....

19-PLACE OF BURIAL OR REMOVAL, *Western Cem* DATE OF BURIAL, *Feb. 21 1922*  
20-UNDERTAKER, *Geo. J. Smith* ADDRESS *1000 W. Myrtle St.*

Remarks

Asphyxia due to cardio renal disease. Had  
chronic heart disease for years.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*,

*peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia," (merely symptomatic), "At-rophy," "Collapse," "Coma," "Convulsions," "De-bility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite dis-ease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicemia," "PUERP-ERAL peritonitis," etc. State cause for which sur-gical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Ex-amples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homi-cide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional in-formation which may give any of the following diseases, without explanation as the sole cause of death:

*Abortion*, *Hemorrhage*, *Meningitis*, *Phlebitis*,  
*Cellulitis*, *Gangrene*, *Miscarriage*, *Pyemia*,  
*Childbirth*, *Gastritis*, *Necrosis*, *Septicemia*,  
*Convulsions*, *Erysipelas*, *Peritonitis*, *Tetanus*.

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61516

D 61516

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 810. W. Saratoga ST. 18 WARD)

## 2-FULL NAME

(a) RESIDENCE. NO. 810. W. Saratoga ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. 1 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Brn 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 25 04

7 AGE Years Months Days 17 1 23 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Walter Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mrs. Bradford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Henrietta Hall 810. W. Saratoga

15 Filed

Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 25, 1921, to Feb 18, 1922.

that I last saw him alive on Feb 17, 1922.

and that death occurred, on the date stated above, at 2.25 P.M.

The CAUSE OF DEATH was as follows: Tuberculosis

CONTRIBUTORY (Secondary) (duration) yrs. 2 mos. ds. As shown

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic

(Signed) J. H. Harrison M. D.

Address 712 S. Park St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

MARGIN RESERVED FOR BINDING  
B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 20 1922

Burial Permit Clerk.





## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61518

D 61518

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1221 Smith*)ST. *16* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. *1221 Smith*

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *30* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*Caucasian*

5 Single, Married, Widowed, or Divorced (write the word)

*widowed*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Solomon Smith*6 DATE OF BIRTH (month, day, and year) *Mar. 15-1861*

7 AGE

*61*

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*House wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

*House work*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

*Robert Blackburn*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

*Martha Johnson*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)*Muriel Smith  
1221 Smith St.*

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 20* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

*Aug 29*, 19*21*, to *Feb. 20*, 19*22*.that I last saw her alive on *Feb. 19*, 19*22*.and that death occurred, on the date stated above, at *10-20 A. M.*

The CAUSE OF DEATH\* was as follows:

*Cerebral hemorrhage*(duration) — yrs. *5* mos. *20* ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
If not at place of death?Did an operation precede death? *no* Date of —Was there an autopsy? *no*What test confirmed diagnosis? *none*

(Signed)

*Chas. Lee Cady, M. D.*2-20-1922 Address *906 N. Strickland St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Anthony**Feb 22-22*

20 UNDERTAKER

ADDRESS

*Sam'l H. Chase Box 1400 N. York St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

D 61519 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: No. 200 Rockdale Ave (Parkburg) ST. (WARD)

## 2. FULL NAME Sarah Scheiblein

(a) RESIDENCE NO. 200 Rockdale Ave.  
(Usual place of abode)

Length of residence in city or town where death occurred

mos.

da.

How long in U. S., if of foreign birth?

yrs.

mos.

da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct. 18 - 1841

7 AGE

Years

Months

Days

If LESS than  
t day, hrs.  
or min.

80

4

—

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore  
Maryland

10 NAME OF FATHER

George Scheiblein

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Barbara Shaffer

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Germany

14

Informant  
(Address)Charles A. Scheiblein  
200 Rockdale Ave.

15

Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 18 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 1920 to Feb. 18 1922

that I last saw her alive on Feb. 18 1922

and that death occurred, on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH\* was as follows:

chronic valvular heart disease

(duration) 2 yrs. mos. da.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. W. W. H. M. D.

Address 2020 N. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St. Mary's (Hampden) Feb. 21 1922

20 UNDERTAKER

ADDRESS

Norah H. Burge

563 Falls Rd.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

B 20 1922

Burial Permit No. 121

D 61520

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61520

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 600 N. 34th St. ST. 13 WARD)

## 2-FULL NAME

Edith Pasch

## (a) RESIDENCE NO.

600 N. 34th St.

ST. 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

1 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

William H. Pasch

6 DATE OF BIRTH (month, day, and year)

March 15-1854

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

67

11

5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Laurel Maryland

## 10 NAME OF FATHER

John B. Arthur

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Laurel Maryland

## 12 MAIDEN NAME OF MOTHER

Marion

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Laurel Maryland

14

Informant (Address)

Mrs. Wallace H. Gier 600 N. 34th St.

15

Filed

Robert F. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20 1922

17

I HEREBY CERTIFY, That I attended deceased from

January 8, 1922 to Feb. 20, 1922.

that I last saw her alive on Feb. 19, 1922.

and that death occurred, on the date stated above, at 5:20 A. M.

The CAUSE OF DEATH\* was as follows:

Acute Pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY Central Hemorrhage (Secondary) Endocarditis, Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Macmillan, M. D.

19 (Address) 4119 Falls Road

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park

Feb. 22 1922

20 UNDERTAKER

ADDRESS

Horace H. Burgee 363 Falls Rd

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificate. TION is very important.

B 201922

Burial Permit Clerk.



MARGIN RESERVED FOR BINDING  
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D 61521 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 D 61521  
CERTIFICATE OF DEATH.

1-PLACE OF DEATH  
CITY OF BALTIMORE: (No. 3828 Park Heights St. WARD) 15  
2-FULL NAME Samuel Laupheimer  
(a) RESIDENCE NO. 3828 Park Heights St. WARD  
(Usual place of abode)  
Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS  
3 SEX Male  
4 COLOR OR RACE White  
5 Single, Married, Widowed, Divorced, (write the word) Married  
5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Laupheimer  
6 DATE OF BIRTH (month, day, and year) Aug. 24 1854  
7 AGE Years 67 Months 6 Days 11 If LESS than 1 day, hrs. or min.  
8 OCCUPATION OF DECEASED  
(a) Trade, profession or particular kind of work furniture obb  
(b) General nature of industry, business, or establishment in which employed (or employer) Salesman  
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Md  
10 NAME OF FATHER Jacob Laupheimer  
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany  
12 MAIDEN NAME OF MOTHER Matilda  
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Mary Laupheimer 3828 Park Heights St  
15 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH  
16 DATE OF DEATH (month, day, and year) Feb. 19 1922  
17 I HEREBY CERTIFY, That I attended deceased from Jan'y 27, 1922, to Feb'y 19, 1922, that I last saw him alive on Feb'y 19, 1922, and that death occurred, on the date stated above, at A. m.  
The CAUSE OF DEATH\* was as follows:

Chronic Nephritis  
Symptoms: 1 yrs. 6 mos. — ds.  
CONTRIBUTORY Uræmia  
(Secondary) (duration) — yrs. — mos. 3 ds.

18 Where was disease contracted If not at place of death?  
Did an operation precede death? No Date of —  
Was there an autopsy? No  
What test confirmed diagnosis?  
(Signed) Louis P. Hamburger, M. D.  
20, 1922 Address 1207 Eutaw Place

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL  
20 UNDERTAKER  
1922 Address  
Feb'y 21 1922  
David Overheim 1182 4th St d e

EB 20 1922

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D 61522

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

St.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Hess

(Address) 1700 Madison Ave.

15-

Filed Robert M. Harrison,

Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, that I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Harrison, M. D.

(Coroner) 1007 4 Address 3022 Polson

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 61523

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 61523

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 622 Gilbert ST., 17 WARD)

2-FULL NAME

(a) RESIDENCE No. 622 Gilbert ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE Col. 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Grace Williams

6 DATE OF BIRTH (month, day, and year) February 15, 1922

7 AGE Years 33 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Common Labor

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Battis (State or country)

10 NAME OF FATHER Chas. H. Williams

11 BIRTHPLACE OF FATHER (city or town) Pa (State or country)

12 MAIDEN NAME OF MOTHER Jane Plummer

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Jane Williams (Address)

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/17/22

17 I HEREBY CERTIFY that I attended deceased from Feb. 15, 1922, to Feb. 17, 1922, that I last saw him alive on Feb. 17, 1922, and that death occurred, on the date stated above, at 11:03 P. M.

The CAUSE OF DEATH\* was as follows:

Toxemia (duration) 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) 7 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) John H. Thompson, M. D.

(Address) 1019 N. Main St., Baltimore

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Samuel Clem Feb 21, 1922

20 UNDERTAKER ADDRESS

Jas. H. Skinner 1625 E. Madison St.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61524		HEALTH DEPARTMENT—CITY OF BALTIMORE		31 D 61524	
CERTIFICATE OF DEATH.					
1-PLACE OF DEATH					
CITY OF BALTIMORE (No. 504 <i>Hummel St.</i> ST. 17 WARD)					
2-FULL NAME <i>Esella Wallay</i>					
(Residence in Baltimore: No. 504 <i>Hummel St.</i> St.; yrs., mos. ds.)					
PERSONAL AND STATISTICAL PARTICULARS.					
3-SEX <i>Female</i>	4-COLOR OR RACE <i>Colored</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) <i>Married</i>	16-DATE OF DEATH, <i>Feb. 17, 1922</i> (Month) (Day) (Year)		
6-DATE OF BIRTH, <i>July 4, 1900</i> (Month) (Day) (Year)			17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.		
7-AGE, <i>22 yrs., 8 mos., 13 ds.</i> If LESS than 1 day, .... hrs. or .... min.?			The CAUSE OF DEATH* was as follows: <i>Pulmonary tuberculosis</i> (Duration) .... yrs. 4 mos. .... ds.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>House work</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>D.C.</i>			CONTRIBUTORY (Secondary) (Duration) .... yrs. .... mos. .... ds.		
9-BIRTHPLACE, (State or Country), <i>Md.</i>			(Signed) <i>J. H. Hennessey</i> , M. D. (Coroner.) <i>Feb. 20, 1922</i> (Address) <i>3802 Hummel St.</i>		
PARENTS.	10-NAME OF FATHER, <i>William Sadner</i>	*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
	11-BIRTHPLACE OF FATHER (State or Country), <i>Md.</i>	18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.			
	12-MAIDEN NAME OF MOTHER, <i>Mary Stewart</i>	Where was disease contracted, if not at place of death? .....			
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Md.</i>	Former or usual residence .....			
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <i>Mrs. M. Wallace</i> (Address) <i>504 Hummel St.</i>			19-PLACE OF BURIAL, OR REMOVAL, <i>Mt Auburn Co.</i> DATE OF BURIAL, <i>Feb. 22 1922</i>		
15- <i>FEB 21 1922</i> Filed. .... 191. .... <i>ROBERT R. KRAUTER</i> <i>BURIAL PERMIT OFFICE</i>			20-UNDERTAKER, <i>Daniel Easton</i> ADDRESS <i>910 Puma</i>		



## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

## CERTIFICATE OF DEATH.

31 D 61525

61525

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2126 Dunsmuir ST., 14 WARD)2-FULL NAME James Wade(a) RESIDENCE NO. 2126 Dunsmuir ST., 14 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Jennie Wade6 DATE OF BIRTH (month, day, and year) Aug 24, 18757 AGE Years 46 Months 5 Days 27 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Charles Co. (State or country) Ind.10 NAME OF FATHER Ignatious Wade11 BIRTHPLACE OF FATHER (city or town) Charles Co. (State or country) Ind.12 MAIDEN NAME OF MOTHER Ann E. Thompson13 BIRTHPLACE OF MOTHER (city or town) Charles Co. (State or country) Ind.14 Informant Sylvia Wade (Address) 2126 Dunsmuir St.15 FEB 21 1922 ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 15, 1921, to Feb 20, 1922, that I last saw him alive on Feb 20, 1922, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis of Lungs(duration) yrs. 8 mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical findings(Signed) William F. Hey, M. D., 19 (Address) 1928 Penna Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Cathedral Cemetery Feb 22, 1922

20 UNDERTAKER

ADDRESS

Harmon D. Wright 364 Mary

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING  
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 61526

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 61526

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1170 Spring Street ST., 3 WARD)

2-FULL NAME

(a) RESIDENCE No. 1170 Spring St ST., 3 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. 8 mos. 8 ds. How long in U. S., if of foreign birth? 8 yrs. 8 mos. 8 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of Emmanuel Weishlatt  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 70 Months — Days — If LESS than 1 day, hrs. — or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia  
(State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Russia  
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Russia  
(State or country)

14 Informant David Schmuckley  
(Address) 2016 E. Lexington St

15 FEB 21 1922 ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20 1922

17

I HEREBY CERTIFY, That I attended deceased from at interval since, 1917 to Feb. 18, 1922.

that I last saw her alive on Feb. 18, 1922.

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis with  
progressive destruction of lungs  
& resulting weakness

(duration) 5+ yrs. — mos. — ds.

CONTRIBUTORY progressive asthma  
(Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Resp. Exam.

(Signed) Frank J. Smith, M. D.

Feb. 20 1922 (Address) 927 E. Calvert St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Mount Carmel

DATE OF BURIAL

2-21 1922

20 UNDERTAKER

ADDRESS

Jack Lewis, 1211 E. Balto

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61527

61527

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No Union Memorial Hospital ST.: 14 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Ross Diffenderffer

(a) RESIDENCE. No Union Memorial Hospital ST. 14 WARD. Woodbrook, Balto. Co.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 2 ds. How long in U. S., if of foreign birth? 63 yrs. 7 mos. 26 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Elizabeth Diffenderffer

6 DATE OF BIRTH (month, day, and year) June-23-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
63	7	26		

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired from the

(b) General nature of industry, business, or establishment in which employed (or employer) firm Evan W. Hook-Co.

(c) Name of employee (Self) E. W. Hook &amp; Co.

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland

10 NAME OF FATHER Octavius Diffenderffer

11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca Crown

13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country) Maryland14 Informant Claude R. Diffenderffer (son)  
(Address) Bellona Av. Woodbrook, Md.15 File FEB 21 1922 ROBERT R. KRAUTER,  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 16, 1922, to Feb 18, 1922.

that I last saw him alive on Feb 18, 1922.

and that death occurred, on the date stated above, at 5:40 p. m.

The CAUSE OF DEATH\* was as follows:

Chronic Typhritis

CONTRIBUTORY Nephritis, Myocarditis, Broncho-pneumonia

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George E. Hardy, M. D.

, 19 (Address) Union Memorial Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

GREEN MOUNT CEMETERY

FEB-21-22

20 STEWART & MOWEN COMPANY  
(WILLIAM F. WOODEN, SUGGESTED)

## ADDRESS

100 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

61528

Spec.—6-9, 19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

61528

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 740 W. Fayette ST. 4 WARD)

### 2-FULL NAME

(a) RESIDENCE. No. 740 W. Fayette ST. 4 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Maguire

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

56

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Police 073

(b) General nature of industry, business, or establishment in which employed (or employer)

B & O R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

John Maguire

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Sarah Foy

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Kate Maguire  
740 W. Fayette St.

15

**FEB 21 1922**

**ROBERT R. KRAUTER,**  
Registrar

Burial Permit No.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to Feb 18, 1922, that I last saw him alive on Feb 18, 1922, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH\* was as follows:

Endocarditis

(duration) yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) Acute Dilatation

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Glassman, M. D.

Address 2687 Madison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cem

Feb 22 1922

20 UNDERTAKER

ADDRESS

Martin Shabaz 1829 North



D 61529 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61529

## CERTIFICATE OF DEATH.

122-002

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 S. Arlington Ave. ST. 18 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Benton

(a) RESIDENCE No. 16 S. Arlington Ave.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 10 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie M. Benton

6 DATE OF BIRTH (month, day, and year) April 11, 1875

7 AGE Years 46 Months 10 Days 13 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Joseph B. Cook

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Charles Benton

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Delia Arthur

13 BIRTHPLACE OF MOTHER (city or town) Ireland. (State or country)

14 Informant Mrs. Nellie M. Benton (Address) 16 S. Arlington Ave.

15 Filed FEB 21 1922 J. E. Cook Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19, 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1922, to Feb. 19, 1922, that I last saw him alive on Feb. 18, 1922, and that death occurred, on the date stated above, at 4.20 A. M.

The CAUSE OF DEATH\* was as follows:

Cerebrovascular disease (duration) yrs. mos. ds. Contributory (Secondary) Coronary Sclerosis 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical (Signed) J. N. Magness, M. D. Feb. 20, 1922 (Address) 14 E. Read St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park

Feb. 22, 1922

20 UNDERTAKER

ADDRESS

J. B. Cook

1003 W. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 61530

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 61530

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 253 Franklin

ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Elmer W. Jones

(a) RESIDENCE. NO. 253 Franklin

ST. 17 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Col. 5 Single, Married, Widowed, or Divorced (write the word) ---

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) July 31, 1921

7 AGE Years 1 Months --- Days 19 If LESS than 1 day, hrs. --- or min. ---

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ---  
(b) General nature of industry, business, or establishment in which employed (or employer) ---  
(c) Name of employer ---

9 BIRTHPLACE (city or town) Baltimore, Md.  
(State or country)

10 NAME OF FATHER Chas. W. Jones

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.  
(State or country)

12 MAIDEN NAME OF MOTHER Christina Evans

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md.  
(State or country)

14 Informant Charles W. Jones  
(Address) 253 W. Franklin St.

15 FEB 21 1922 ROBERT N. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1922, to July 19, 1922, that I last saw him alive on July 18, 1922, and that death occurred, on the date stated above, at 2 A. M.  
The CAUSE OF DEATH\* was as follows:  
Pneumonia

CONTRIBUTORY (Secondary) Exhaustion  
(duration) yrs. mos. ds.

18 Where was disease contracted ---  
If not at place of death?

Did an operation precede death? no Date of ---

Was there an autopsy? no

What test confirmed diagnosis?  
(Signed) Dr. Wm. Wagner, M. D.  
re. 1922 (Address) 1006 Edmondson

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery DATE OF BURIAL 2/28/22

20 UNDERTAKER J. B. Pope, 102 E. Mulberry St.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior.*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 61531

HEALTH DEPARTMENT—CITY OF BALTIMORE D 61531

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 N. Eden ST.: 5 WARD)

2-FULL NAME

Julio Barnes

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 412 N. Eden ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred 5 mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Married  
5a If married, widowed, or divorced, name of (husband or) WIFE of Eliza Barnes  
6 DATE OF BIRTH (month, day, and year) Sept. 21 1876  
7 AGE Years 45 Months 5 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 037  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Vermont N.C.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Charles Barnes 412 N. Eden St.

15 FEB 21 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/18 1922  
17 I HEREBY CERTIFY, That I attended deceased from 2/16 1922, to 2/18 1922, that I last saw her alive on 2/18 1922, and that death occurred, on the date stated above, at 4:15 P. M.  
The CAUSE OF DEATH\* was as follows:

Parenchymatous Nephritis  
(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia  
(duration) yrs. mos. ds. 3

18 Where was disease contracted If not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Lab test.  
(Signed) Ralph J. Young, M. D.

19 (Address) 1429 E. Monument St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER Samuel Hensley

ADDRESS 578



D 61532

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61532

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital* ST. *70* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs Eva Finkelstein*(a) RESIDENCE. NO. *2048 Hollins Ave* ST. *70* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *15* yrs. mos. ds.How long in U. S., if of foreign birth? *15* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Unknown*7 AGE *49* Years Months Days If LESS than 1 day, hrs. or min.8 OCCUPATION OF DECEASED *Housewife*

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Russia*10 NAME OF FATHER *Y. K.*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Russia*12 MAIDEN NAME OF MOTHER *W. K.*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Russia*14 Informant *James Finkelstein* (Address) *2048 Hollins St.*15 Filed *FEB 21 1922* ROBERT R. KRAUTER, Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/20* 19*22*17 I HEREBY CERTIFY, That I, attended deceased from *Feb 17th*, 19*22*, to *Feb 20*, 19*22*.that I last saw him alive on *Feb 20th*, 19*22*.and that death occurred, on the date stated above, at *3:00 P.* m.

The CAUSE OF DEATH\* was as follows:

*Terminal Broncho Pneumonia*CONTRIBUTORY (Secondary) *11 Encephalitis of G. B. Heller* (duration) *2* yrs. mos. ds. *10 days*

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *Yes* Date of *Feb 17th*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *A. Heller, M. D.*20, 19*22* Address) *Hebrew Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Hebrew Rosedale Bur.* 19*22*

20 UNDERTAKER

ADDRESS *1127 E. Balto St.**M. Linsor*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Eka.

D 61533 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61533

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 Calver Ave

ST.: 9

WARD)

2-FULL NAME

Bridget Larkin

(a) RESIDENCE. No. 714 Calver Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 50 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Thos J Larkin

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

78

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

Edw Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary Duffy

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Thomas Larkin 714 Calver Ave

15

FEB 21 1922

ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 19 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 18 1922 to Feb 19 1922

that I last saw her alive on Feb 18 1922

and that death occurred, on the date stated above, at 6 4 m.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Kelly M. D.

20 19 22 Address 110 E. Pratt Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral

Feb 22 1922

20 UNDERTAKER

ADDRESS

E. A. Wiedefeld Jr

501 E 22 St

# Ciccolotti

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61534

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Municipal Hospital* ST. *16* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*Louis Ciccolotti*(Residence in Baltimore: No. *Municipal Bldg.* St. *2 hrs.* yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Male*

## 4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

## 6-DATE OF BIRTH

*Feb 18 1912*  
(Month) (Day) (Year)

## 7-AGE

*5* yrs. mos. ds.

If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*  
(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE (State or Country).

*Balto Co*

## 10-NAME OF FATHER

*Louis Ciccolotti*

## 11-BIRTHPLACE OF FATHER (State or Country)

*Italy*

## 12-MAIDEN NAME OF MOTHER

*Not known*

## 13-BIRTHPLACE OF MOTHER (State or Country)

*Italy*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John P. P. P.*(Address) *Mass. Ave. & Eastern Ave.*

## 15-

Filed *FEB 21 1922* 191. *ROBERT N. KRAUTER*

Registrar.

Burial Permit *1015*

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*Feb 18 1922*  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *Feb 10 1922* to *Feb 18 1922*, that I saw him alive on *Feb 18 1922*, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

*typhoid fever*..... (Duration) ..... yrs. .... mos. .... ds.  
CONTRIBUTORY (Secondary) *Endocarditis*..... (Duration) ..... yrs. .... mos. .... ds.  
(Signed) *Maxwell J. Mayer* M. D.  
....., 191... (Address) *314 S. Baltimore*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted if not at place of death? *Municipal Hospital*Former or usual residence *Essex Md.*

## 19-PLACE OF BURIAL OR REMOVAL

*Oak Lawn Cem.*

## DATE OF BURIAL

*Feb 21 1922*

## 20-UNDERTAKER

*John Henry & Co.*

## ADDRESS

*208 E. ...*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

844  
D 61535

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

✓ 002  
101  
D 61535

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Loretta Polomba

(a) RESIDENCE. NO. 811 Greenmount Ave. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 5 - 1921

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 1 — 15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) MD.

10 NAME OF FATHER Joe Polomba

11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)

12 MAIDEN NAME OF MOTHER Mary Patone

13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records

15 Filed FEB 21 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20 - 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 13 - 1922, to Feb. 20 - 1922

that I last saw h. alive on Feb. 20 - 1922

and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH\* was as follows: Pneumonia (Primary)

(duration) yrs. mos. 10 da.

CONTRIBUTORY Emphysema (Secondary)

(duration) yrs. mos. 6 da.

18 Where was disease contracted Home if not at place of death?

Did an operation precede death? No Date of 7/18/22

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Horace G. Stewart M. D.

No 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Redeemer Ch. 7/21/22

20 UNDERTAKER ADDRESS

George J. Rutt 1735 Hayford



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D 61536

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 61536

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 Cottage Ave. Easton Heights ST., 11-001 WARD)

2. FULL NAME Henry Netzel

(a) RESIDENCE No. 2 Cottage Ave. Easton Heights ST., 11-001 WARD  
(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred 5 yrs. 2 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 16<sup>th</sup> 1916  
7 AGE Years 5 Months 2 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) import

(c) Name of employer none

9 BIRTHPLACE (city or town) Balto. (State or country) Maryland.

10 NAME OF FATHER Peter Netzel

11 BIRTHPLACE OF FATHER (city or town) Ellerin (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Krane

13 BIRTHPLACE OF MOTHER (city or town) Einbrant (State or country) Germany

14 Informant Peter Netzel (Address) 2 Cottage Ave. Radeborg.

15 FEB 21 1922 ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1922, to Feb 20, 1922, that I last saw him alive on Feb 20, 1922, and that death occurred, on the date stated above, at 7 a. m.  
The CAUSE OF DEATH\* was as follows:

Capillary thromb.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Influenza (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) James H. Hager, M. D.

Feb 20, 1922 (Address) 10145 Elmwood Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Parkwood Cemetery DATE OF BURIAL Feb 22 1922

20 UNDERTAKER Frank Lessahn Sons ADDRESS Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 7 WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15

Filed

Feb 21 1922

ROBERT R. KRAUTER,  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 18<sup>th</sup>, 1922, to Feb. 21<sup>st</sup>, 1922,

that I last saw him alive on Feb. 21<sup>st</sup>, 1922,

and that death occurred, on the date stated above, at 4:20 p.m.

The CAUSE OF DEATH\* was as follows:

BRAIN TUMOR

CONTRIBUTORY  
(Secondary)

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Yes Date of 2-20-22

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. L. Dorsey, M. D.

, 19 (Address) 4-H-H.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Wilson & Co

Feb 21 1922

20 UNDERTAKER

ADDRESS

Joseph Ahrens

221 N. Bay

Additional information from father.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61538

CERTIFICATE OF DEATH.

61538

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2421 Woodbrook Ave. 3 WARD)

2. FULL NAME

Lina Weiskopf

(a) RESIDENCE No.

2421 Woodbrook Ave

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred. 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) February

7 AGE 52 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City (State or country)

10 NAME OF FATHER Joseph L. Weiskopf

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Cecelia Rice

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant (Address) Lina Weiskopf Baltimore

15 Filed FEB 21 1922 ROBERT R. KRALTER Registrar

Burial Permit Clerk,

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 20, 1921 to Feb 20, 1922 that I last saw him alive on Feb 18, 1922 and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH\* was as follows:

Mitral Regurgitation + Cardiac Dilatation, also Chronic interstitial nephritis (duration) 1 yrs. 1 mos. 1 ds.

CONTRIBUTORY Pulmonary Oedema (Secondary) + Exhaustion (duration) 1 yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine tests for above (Signed) Thomas J. Jacobson M. D.

(Address) 321, 1922 Address) Marlborough Apt

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Hebrew Fresh Feb 22 1922

20 UNDERTAKER

ADDRESS

J. Ahrens & Co 16 Maryland Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 61539

HEALTH DEPARTMENT—CITY OF BALTIMORE

61539

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland Penitentiary* ST. *17* WARD)

2-FULL NAME

(a) RESIDENCE. No. *532 1/2 Greenwillow* ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Black* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May - 19 - 1883*

7 AGE Years *39* Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Maryland* (State or country)

10 NAME OF FATHER *Louis Bratman*

11 BIRTHPLACE OF FATHER (city or town) *unknown* (State or country)

12 MAIDEN NAME OF MOTHER *Julia Soaga*

13 BIRTHPLACE OF MOTHER (city or town) *unknown* (State or country)

14 Informant (Address) *Robert P. Harrison, Registrar*

15 *Robert P. Harrison, Registrar*

*Robert P. Harrison, Registrar*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *February - 20 - 1922*

17 I HEREBY CERTIFY, That I attended deceased from *September - 23 - 1921* to *February - 20 - 1922*

that I last saw him alive on *February - 19 - 1922*

and that death occurred, on the date stated above, at *6:15 a. m.*

The CAUSE OF DEATH\* was as follows:

*Exhaustion - Pulmonary Hemorrhage* (duration) yrs. *4* mos. *1* ds.

CONTRIBUTORY *Pulmonary tuberculosis* (Secondary) (duration) yrs. *4* mos. *27* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Examination of Sputum*

(Signed) *William R. Selward*, M. D. 20, 1922 Address *MD Penitentiary*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Mt. Auburn* *2 - 22 - 1922*

20 UNDERTAKER ADDRESS

*J. H. Sadler* *142 W. ...*



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 61540

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61540

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 645 St Lee ST., 27 WARD)

2-FULL NAME

Harry M Smith

(a) RESIDENCE NO.

645 St. Lee

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

62 yrs. 2 mos. 24 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of

Mary E Smith

6 DATE OF BIRTH (month, day, and year)

Nov 28 1859

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

62

2

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Jacob F Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md

12 MAIDEN NAME OF MOTHER

Maria Bergalt

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md

14

Informant (Address)

Mary E Smith  
645 St Lee St

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug, 1921, to Feb 20, 1922.

that I last saw him alive on Feb 20, 1922.

and that death occurred, on the date stated above, at 2 25 a.m.

The CAUSE OF DEATH\* was as follows:

Lympho Sarcoma of neck

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. E. Munn, M. D.

(Address) 1520 Hollins St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mount Olivet

DATE OF BURIAL

Feb 23 1922

20 UNDERTAKER

John F Denny

ADDRESS

715 Light St

FEB 21 1922

Burial Permit Clerk.

D 61541

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61541

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 672 W Saratoga ST., 4 WARD)

## 2-FULL NAME

Rosie Serio

## (a) RESIDENCE NO.

672 W Saratoga ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Antonio Serio

6 DATE OF BIRTH (month, day, and year)

Sept 27 1888

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

33

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Italy

10 NAME OF FATHER

Mariano Pulcinella

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

12 MAIDEN NAME OF MOTHER

Maria Restivo

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Italy

14

Informant (Address)

Antonio Serio 672 W Saratoga ST

FEB 21 1922

Robert P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

2-20 1922

17

I HEREBY CERTIFY, That I attended deceased from

7-11-1919 to 2-20 1922

that I last saw him alive on 2-20-1922

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH\* was as follows:

Sarcoma of Femur.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. 7 mos. 9 ds.

Gangrene of leg

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

No

Did an operation precede death? Date of

No

Was there an autopsy?

No

What test confirmed diagnosis?

X Ray plates

(Signed)

S. J. Dineen, M. D.

, 19

(Address)

604 Linden Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Cathedral Cemetery

Feb 21 1922

20 UNDERTAKER

ADDRESS

H. M. Roulton

2238 N. Ant

D 61542

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61542

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1048 Brentwood Ave

WARD)

## 2-FULL NAME

Martha J. Perry

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE

No. 1048 Brentwood Ave

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

70 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Wife of Wm B Perry

6 DATE OF BIRTH (month, day, and year)

Oct 23-1837

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

84

3

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House

(b) General nature of industry, business, or establishment in which employed (or employer)

House

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Cecil Co Md

10 NAME OF FATHER

Chas H. Crouch

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Caroline May

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

W. B. Perry

1 W. Biddle St

Robert F. Harrison,

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 20 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 1 1921 to Feb 20 1922

that I last saw him alive on Feb 20 1922

and that death occurred, on the date stated above, at 8.30 p.m.

The CAUSE OF DEATH\* was as follows:

Arterial Sclerosis

CONTRIBUTORY (Secondary)

(duration) 2 yrs. 2 mos. 2 ds. dilatation of heart

18 Where was disease contracted if not at place of death?

Did an operation precede death? 20 Date of

Was there an autopsy? 20

What test confirmed diagnosis? 400

(Signed) Wm B Perry M. D.

, 19 (Address) 1 W. Biddle St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Green Mount

Feb 23 1922

20 UNDERTAKER

ADDRESS

H. C. Weddell

914 Green Mt Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FEB 21 1922

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 61543

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61543

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE, No. 404 E Chase ST., 10 WARD

2. FULL NAME

Theresa A. Sadler

(a) RESIDENCE NO.

404 E Chase

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life

mos.

ys.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

J. Warren Sadler

6 DATE OF BIRTH (month, day, and year)

7 AGE

Year

Months

Days

If LESS than 1 day, hrs. or min.

82

7

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

MD

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

MD

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

MD

14

Informant (Address)

Edna C. Walz  
404 E Chase St.

15

Robert P. Harrison,

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

164

WARD

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

2/20 1922

17

I HEREBY CERTIFY, That I attended deceased from

1/28, 1922, to 2/20, 1922.

that I last saw him alive on 2/18, 1922.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Older of lungs

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Dr. Bernard Weiss, M. D.

Address 914 E. Biddle St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVA

Baltimore

DATE OF BURIAL

Feb 22 1922

20 UNDERTAKER

W. E. Wedefeld 914 Biddle St.

FEB 21 1922



B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61544

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital WARD)

2-FULL NAME Benjamin Sampson

(a) RESIDENCE No. 125 Schroeder st.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE Years 39 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Albert Sampson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) M.T.H.

15 Robert F. Harrison Registrar

Burial Permit 61021

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17, 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1922, to Feb. 17, 1922.

that I last saw him alive on Feb. 16, 1922.

and that death occurred, on the date stated above, at 4.20 P. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY Generalized tuberculosis (Secondary)

(duration) yrs. 6 mos. ds.

18 Where was disease contracted Unknown If not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis T. B. in sputum

(Signed) Francis D. Dugliano M. D.

(Address) Municipal Tbc. Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL DATE OF BURIAL

20 UNDERTAKER Commissioner Health,

ADDRESS

FEB 21 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61545

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *608 Fair Oaks Av* ST. *9* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *608 Fair Oaks Av* St.; ..... yrs., ..... mos. .... ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

## 6-DATE OF BIRTH

*Feb. 20*, 19*22*  
(Month) (Day) (Year)

## 7-AGE

..... yrs. .... mos. .... ds.

If LESS than 1 day,

*18* hrs. or .... min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

## 9-BIRTHPLACE, (State or Country),

*Baltimore Md.*

## 10-NAME OF FATHER,

*George Warren Gebold*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Md.*

## 12-MAIDEN NAME OF MOTHER

*Mary Dorothy Baker*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Va.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *F. Gill Hall M.D.*(Address) *1617 E. North Ave.*

## 15-

*Robert H. Harrison*

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Feb. 20*, 19*22*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Feb. 20* 19*22*, to *Feb 20* 19*22*,that I saw her alive on *Feb 20* 19*22*,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH\* was as follows:

*Permatene Birth 6 1/2 months  
chloroform*  
*18 hrs*

(Duration) ..... yrs. .... mos. .... ds.

## CONTRIBUTORY (Secondary)

(Duration) ..... yrs. .... mos. .... ds.

(Signed) *Blaine Gill Hall* M. D.*Feb 21*, 19*22* (Address) *10112 North Ave.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*JOHNS HOPKINS HOSPITAL*....., 19*22*

## 20-UNDERTAKER

## ADDRESS

*Commissioner Health**FEB 21 1922*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

FEB 21 1922

Burial Permit Clerk

1893A

T  
E  
F  
A  
S  
K  
A

D 61546

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED No. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *608 Fair Lake Ave* ST. *9* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *608 Fair Lake Ave* St. *9* yrs. *1* mos. *1* da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH *Feb. 20*, 1922  
(Month) (Day) (Year)

7-AGE, *15* hrs. or *15* mos. *1* da.  
If LESS than 1 day, yrs. mos. da.

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work *Student*  
(b) General nature of industry, business, or establishment in which employed (or employer) *None*

9-BIRTHPLACE, (State or Country), *Ind.*

10-NAME OF FATHER, *George Warren Gebold*

11-BIRTHPLACE OF FATHER (State or Country), *Ind.*

12-MAIDEN NAME OF MOTHER *Mary Dorothy Baker*

13-BIRTHPLACE OF MOTHER (State or Country), *Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *E. Lill Hall* *Ind.*(Address) *1617 E. North Ave*

15-

Filed

*Robert P. Garrison*

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Feb. 20*, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Feb. 20* 1922, to *Feb. 20* 1922,that I saw her alive on *Feb. 20* 1922,and that death occurred, on the date stated above, at *6 PM* *10 PM* m.

The CAUSE OF DEATH\* was as follows:

*Premature Birth - 6 1/2 months*  
*duration - 15 hrs - 16 hrs*  
(Duration) yrs. mos. da.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. da.

(Signed) *Elmer Gell Hall* M. D.*Feb. 21*, 1922 (Address) *1617 E. North Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL  
*JOHNS HOPKINS HOSPITAL*

DATE OF BURIAL,

1922

20-UNDERTAKER

*Commissioner Health*

ADDRESS

*FEB 21 1922*

FEB 21 1922

*1617 E. North Ave**18932*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

11B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 61547 HEALTH DEPARTMENT—CITY OF BALTIMORE  
CERTIFICATE OF DEATH. 31 D 61547

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Schaffer

(a) RESIDENCE. NO. 126 N. Montford Ave. ST.      WARD.     

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

ds. How long in U. S., if of foreign birth? Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not recorded

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE Years 34 Months      Days      If LESS than 1 day, hrs.      or min.     

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Louis Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Warner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records

(Address) M.T.H.

15 Robert P. Harrison Registrar

Death Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19, 1922

17 I HEREBY CERTIFY, That I attended deceased from February 9, 1922, to Feb. 19, 1922, that I last saw him alive on Feb. 19, 1922, and that death occurred, on the date stated above, at 6.15 p.m. The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? T.P. in sputum, X-ray

(Signed) Francis L. Dada M.D.

2-20-22 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Oak Lawn Cemetery Feb 22 1922

20 UNDERTAKER ADDRESS

Mrs C. Miller 2334 Jefferson



or-  
item-  
Every item should be stated EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCASION.  
THIS IS A PERMANENT RECORD. WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCASION.  
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 6-9-10 H. B. C. 1000 Bks.

61548

# HEALTH DEPARTMENT—CITY OF BALTIMORE

61548

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. 11 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) single  
6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 21 1913  
7 AGE Years 8 Months 11 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant

15

Filed

Robert P. Harrison

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 6 1921 to Feb 20 1922 that I last saw her alive on Feb 19 1922 and that death occurred, on the date stated above, at 7:35 A.m.  
The CAUSE OF DEATH\* was as follows:

Mitral Insufficiency

CONTRIBUTORY

(Secondary)

General Anasarca 4 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

2/20 1922

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary

Feb 22 1922

20 UNDERTAKER

John H. Weber

ADDRESS

1803 Bank

D 61549

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61549

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *133 W-20 St* ST. *12* WARD)2-FULL NAME *Francis Smith*(Residence in Baltimore: No. *133 W-20 St*)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*  
(Write the word.)6-DATE OF BIRTH, *1*

(Month) (Day) (Year)

7-AGE, *2* yrs., *2* mos., *2* ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Balto md*

PARENTS.

10-NAME OF FATHER, *William Johnson*11-BIRTHPLACE OF FATHER (State or Country), *Phila Pa*12-MAIDEN NAME OF MOTHER, *Rosie Smith*13-BIRTHPLACE OF MOTHER (State or Country), *Macon Georgia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Rosie Smith*(Address) *133 W-20 St*

15-

Robert P. Harrison,

Filed *1922* 191

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb 20*, 19*22*

(Month) (Day) (Year)

17-

I HEREBY CERTIFY, that I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by an

(Inquest)

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Broncho Pneumonia*

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Signed) *Rosie Smith* (Coroner)1912 (Address) *7632 Rolafida*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Laurel Cem*DATE OF BURIAL, *Feb 22*, 19*22*20-UNDERTAKER, *Joseph A. Farrell*ADDRESS, *1312 Duval St*

B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

61550

## CERTIFICATE OF DEATH.

REGISTERED NO. C

61550

### 1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

Robert P. Harrison,

Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said (Inquest, au-

opsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Harrison, M. D.

(Coroner.)

Feb. 21, 1922 (Address) 302 E. ...

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

EB 21 1922

Burial Permit Clerk.



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 61551

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61551

CERTIFICATE OF DEATH

1-PLACE OF DEATH *Robert Garrett Hospital for Children* REGISTERED NO. *32*  
CITY OF BALTIMORE: (No. *27 N Carey* ST. *3* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
2-FULL NAME *Martha Israel*  
(a) RESIDENCE. No. *13 South Bond* ST., \_\_\_\_\_ WARD. \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred *1* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *single*  
6a If married, widowed, or divorced HUSBAND of \_\_\_\_\_ (or) WIFE of \_\_\_\_\_  
6 DATE OF BIRTH (month, day, and year) *Feb 5 1920*  
7 AGE Years \_\_\_\_\_ Months \_\_\_\_\_ Days *16* If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country)

10 NAME OF FATHER *David Israel*

11 BIRTHPLACE OF FATHER (city or town) *Russia*  
(State or country)

12 MAIDEN NAME OF MOTHER *Jesse Javosh*

13 BIRTHPLACE OF MOTHER (city or town) *Russia*  
(State or country)

14 Informant *Robert Garrett Hospital*  
(Address) \_\_\_\_\_

15 Filed *FEB 22 1922* *ROBERT R. KRAUTER,*  
Burial Permit Number \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 21 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Feb 19<sup>th</sup>*, 19*22*, to *Feb 21*, 19*22*, that I last saw her alive on *Feb 21*, 19*22*, and that death occurred, on the date stated above, at *7:10 P.m.*  
The CAUSE OF DEATH\* was as follows:

*Tuberculous Meningitis*

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted if not at place of death? *unknown*

Did an operation precede death? *no* Date of \_\_\_\_\_

Was there an autopsy? *no—refused.*

What test confirmed diagnosis? *Physical & Laboratory*

(Signed) *J. B. V. Clift*, M. D.

*2/21, 1922* Address) *27 N. Carey*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Rosedale Park* *Feb 22 1922*  
20 UNDERTAKER *John Jones* ADDRESS *1439 N. Carey*



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61552

## CERTIFICATE OF DEATH.

51 D 61552  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1. PLACE OF DEATH

CITY OF BALTIMORE, MD. *433 E North Ave* WARD *2*

### 2. FULL NAME

*Virginia B Woods*

### (a) RESIDENCE NO.

*433 E North Ave*

### WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *3* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth *Life* yrs. *0* mos. *0* ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *June 20 1915*

7 AGE Years *6* Months *7* Days *0* If LESS than 1 day, hrs. *0* or min. *0*

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

*None*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Richmond Va*

10 NAME OF FATHER

*William R Woods*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*North Carolina*

12 MAIDEN NAME OF MOTHER

*Emma Ellen*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Pa*

### PARENTS

14 Informant (Address)

*Emma B Woods*  
*433 E North Ave*

### 15

*FEB 22 1922*

*ROBERT A. KRAUTER*  
Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 19 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Feb 13 1922* to *Feb 20 1922* that I last saw him alive on *Feb 20 1922* and that death occurred, on the date stated above, at *6 P.* m.

The CAUSE OF DEATH\* was as follows:

*Articular Rheumatism*

(duration) yrs. *0* mos. *21* ds.

CONTRIBUTORY (Secondary)

*Heart failure*

(duration) yrs. *0* mos. *0* ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Reginald J. Toney M. D.*

, 19 (Address) *4142 North Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Woodlawn Cemetery* *Feb 23 1922*

19 UNDERTAKER

ADDRESS

*W. L. ...* *502 E North Ave*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61553

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes Hospital* ST. WARD)

### 2-FULL NAME

(a) RESIDENCE NO. *Menokin Somerset Co. Md.* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Yrs. *1* Mos. *5* Ds.

How long in U. S., if of foreign birth? *Life*

(If non-resident, give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

*Mrs. Mamie Dorsey*

6 DATE OF BIRTH (month, day, and year)

*1853*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*69 yrs*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Carpenter*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Somerset Co. Md.*

10 NAME OF FATHER

*Robert Dorsey*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Somerset Co. Md.*

12 MAIDEN NAME OF MOTHER

*Margaret McElaney*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Somerset Co. Md.*

14

Informant (Address)

*Mrs. Mamie Dorsey Somerset Co. Md.*

15

Filed *Feb 22 1922*

ROBERT H. KRAUTER

Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb 21 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*1-21 1922* to *2-21 1922*

that I last saw him alive on *2-21 1922*

and that death occurred, on the date stated above, at *11 A* m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma Forehead and neck-Extension to Bones of skull-*

(duration) *7* yrs. *3* mos. *3* ds.

CONTRIBUTORY (Secondary) *Streptococcus meningitis-*

(duration) *3* yrs. *3* mos. *3* ds.

18 Where was disease contracted

if not at place of death? *Home, 1-24-22.*

Did an operation precede death? *yes* Date of *2-18-22*

Was there an autopsy? *no-*

What test confirmed diagnosis? *Microscopic Exam.*

(Signed) *W.C. Caldwell*, M. D.

, 19 (Address) *St. Agnes Hosp-*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Westover, Somerset Co. Md.*

DATE OF BURIAL

*2-22 1922*

20 UNDERTAKER

*Williams Cook*

ADDRESS

*502 E. North Ave.*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

D 61554

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61554

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1447 Ward St. ST.; 21 WARD)

2-FULL NAME Mr. G. Chambers

(a) RESIDENCE. No. 1417 Ward ST., 21 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Caucasian 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE Years 49 Months Days If LESS than 1 day, 0 hrs. or 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) Not known (State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country)

14 Informant Daniel Easton (Address) 916 S. A. Ave.

15 Filed FEB 22 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1922, to Feb 17, 1922, that I last saw him alive on Feb 19, 1922, and that death occurred, on the date stated above, at 8:00 m. The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis (duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) (duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James Boyd, M. D.

2-24, 1922 Address 602 Columbia

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Not known Feb 23 1922

20 UNDERTAKER ADDRESS 916 S. A. Ave.

Daniel Easton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61555

CERTIFICATE OF DEATH.

D 61555

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

FEB 22 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

2-19-1922, to 2-20-1922

that I last saw him alive on 2-19-1922,

and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH\* was as follows:

La Grippe

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. B. O'Brien, M. D.

(Address) 1618 Calhoun

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

61556 HEALTH DEPARTMENT—CITY OF BALTIMORE  
CERTIFICATE OF DEATH. 129 D 61556

1-PLACE OF DEATH  
CITY OF BALTIMORE: No. *St. Joseph's Hospital* ST. *9* WARD)  
2-FULL NAME *John Pfadenhauer*  
(a) RESIDENCE. No. *Orderly St. Joseph's Hospital* ST. *9* WARD.  
(Usual place of abode)  
Length of residence in city or town where death occurred *37* yrs. mos. ds. How long in U. S., if of foreign birth? *Germany* mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>male</i>	4 COLOR OR RACE <i>white</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Widowed</i>
5a If married, widowed, or divorced HUSBAND of <i>late Mary Pfadenhauer</i> (or <i>Wife of</i> )		
6 DATE OF BIRTH (month, day, and year) <i>Nov Km</i>		
7 AGE	Years <i>64</i>	Months <i>—</i>
	Days <i>—</i>	If LESS than 1 day, hrs. or min. <i>—</i>
8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work <i>Orderly at St. Joseph's Hosp</i> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		
9 BIRTHPLACE (city or town) <i>Germany</i> (State or country)		
10 NAME OF FATHER <i>Nov Km</i>		
11 BIRTHPLACE OF FATHER (city or town) <i>Nov Km</i> (State or country)		
12 MAIDEN NAME OF MOTHER <i>Nov Km</i>		
13 BIRTHPLACE OF MOTHER (city or town) <i>Nov Km</i> (State or country)		

14 Informant *Mr. John Pfadenhauer*  
(Address) *3708 Fernwood Ave*

15 *FEB 22 1922* ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 19 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Dec. 27, 1922* to *Feb. 19, 1922* that I last saw him alive on *Feb. 19, 1922* and that death occurred, on the date stated above, at *8:40 p.m.* The CAUSE OF DEATH\* was as follows:  
*Myocardial Insufficiency*  
(duration) *2* yrs. mos. ds.  
CONTRIBUTORY *Hemiplegia (Chr. degenerative)*  
(Secondary) (duration) *8* yrs. mos. ds.  
18 Where was disease contracted  
If not at place of death?  
Did an operation precede death? *No* Date of  
Was there an autopsy? *No*  
What test confirmed diagnosis? *P. E. & S.*  
(Signed) *Frank E. Manno* M. D.  
, 19 (Address) *St. Joseph's Hospital*  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Sacred Heart Cemetery* DATE OF BURIAL *Feb. 23 1922*

20 UNDERTAKER *Henry Hoeck Son* ADDRESS *1301 E. Eager*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

61557

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ST.

WARD.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed or divorced (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

FEB 22 1922

ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from 8-6, 1921, to 2-20, 1922, (that I last saw him alive on 2-19-22, and that death occurred, on the date stated above, at 10:20 a.m. The CAUSE OF DEATH\* was as follows:

Carcinoma of the uterus (duration) 6 yrs. 14 mos. 14 ds. CONTRIBUTORY (Secondary) Dysmenorrhea (duration) yrs. mos. ds.

18 Where was disease contracted (if not at place of death?)

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Microscopical exam. (Signed) George Abner Bump, M. D. 720 1922 Address 1517 E North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL

Baltimore Armdy February 23 1922

20 UNDERTAKER

Herry Hook Len 1301 E Eager

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61558

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No.

Lombard &amp; Green ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary Agnes Scott

(a) RESIDENCE NO.

Rock Hill Md.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 2 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

— 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Rock Hill Md.

10 NAME OF FATHER

Geo Scott

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Mary Thompson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

14

Informant (Address)

University Hospital, Bc

15

FEB 22 1922

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 18 1922

17

HEREBY CERTIFY, that I attended deceased from

Jan 31, 1922, to July 18, 1922

that I last saw her alive on July 18, 1922

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY

(Secondary)

accident waiting life

(duration) yrs. 1 mos. 12 ds.

18 Where was disease contracted

If not at place of death?

Rock Hill Md.

Did an operation precede death?

Yes

Date of

2/8/22

Was there an autopsy?

No

What test confirmed diagnosis?

Asphyxia

(Signed)

J. B. Jones

M. D.

(Address)

University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Rock Hill, Kent Co., Md.

DATE OF BURIAL

Feb 22 1922

20 UNDERTAKER

Geo. W. Johnson

ADDRESS

1234 E. 1st St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61559

## CERTIFICATE OF DEATH.

D 61559

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 638 W Mulberry ST., 17 WARD)

2-FULL NAME Vincent J. Tuminello Jr

(a) RESIDENCE NO. 638 W Mulberry ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 28, 1921

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 7 27

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

10 NAME OF FATHER Vincent Tuminello

11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)

12 MAIDEN NAME OF MOTHER Mary Casco

13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)

14 Informant Vincent Tuminello (Address) 638 W Mulberry St

15 FEB 22 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1922, to Feb. 21, 1922,

that I last saw him alive on Feb. 20, 1922,

and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 10 ds.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted Home if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Herbert C. Blake M. D.

, 19 (Address) 1014 W La Fayette

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL New Cathedral Ave DATE OF BURIAL July 22, 1922

20 UNDERTAKER John O. Mitchell ADDRESS 1201 N. Gay



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 61560 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO Municipal Tuberculosis Hospital 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Cavey

(a) RESIDENCE. NO. 72 Brick Hill, Mt. Vernon, Mill 3 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

William H. Cavey

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE Years 55 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER William Watts

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER Elsie McKenzy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14 Informant Hospital Records (Address) M.T.H.

15 FEB 22 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21, 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1922 to Feb. 21, 1922, that I last saw him alive on Feb. 21, 1922.

and that death occurred, on the date stated above, at 8.20 a. m. The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 dn.

CONTRIBUTORY Incipient pulmonary tuberculosis (Secondary) (duration) 6 yrs. mos. dn.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sputum examination

(Signed) Frank L. DeGhella, M.D.

2-21-22 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cella Room 14 Feb 24 1922

20 UNDERTAKER

ADDRESS

Chenoweth Son Chestnut St

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD--PHYSICIANS should state N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61561

HEALTH DEPARTMENT--CITY OF BALTIMORE

160 D 61561

CERTIFICATE OF DEATH.

1-PLACE OF DEATH  
CITY OF BALTIMORE (No. 3823 Pleasant Place) ST. 16 WARD 5

2-FULL NAME Mildred C. Krifer  
(Residence in Baltimore: No. 2823 Pleasant Place St.: yrs. mos. ds.)

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWER, OR DIVORCED Child  
(Write the word.)

6-DATE OF BIRTH Oct 11, 1921  
(Month) (Day) (Year)

7-AGE 4 yrs. 8 mos. 8 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work... Child  
(b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.  
10-NAME OF FATHER, George Krifer  
11-BIRTHPLACE OF FATHER (State or Country), MD  
12-MAIDEN NAME OF MOTHER Emma Jingling  
13-BIRTHPLACE OF MOTHER (State or Country), MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) George Krifer  
(Address) 3823 Pleasant Place

15-ROBERT R. KRAUTER,  
Filed FEB 22 1922 Burial Permit Class

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Feb 20, 1922  
(Month) (Day) (Year)

17-I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest find that said deceased came to death on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
Parasomnia  
(Duration) yrs. mos. ds.  
CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.  
(Signed) J. H. Homan M. D. (Coroner)  
(Address) 3823 Pleasant  
State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).  
At place of death... yrs. mos. ds. In the State... yrs. mos. ds.  
Where was disease contracted, if not at place of death? ...  
Former or usual residence...  
19-PLACE OF BURIAL OR REMOVAL, St Marys Cemetery DATE OF BURIAL, Feb 22 1922  
20-UNDERTAKER, Chenoweth & Co ADDRESS Chestnut St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61562

CERTIFICATE OF DEATH.

44 D 61562

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 N. Bruce St ST., 19 WARD)

2. FULL NAME

Israel Butler

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

231 N. Bruce St

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Emmum

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

62

—

—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

md

10 NAME OF FATHER

Israel Butler

11 BIRTHPLACE OF FATHER (city or town)

md

(State or country)

12 MAIDEN NAME OF MOTHER

Jannie Hayes

13 BIRTHPLACE OF MOTHER (city or town)

md

(State or country)

14

Informant

Fred Butler

(Address)

231 N Bruce St

15

Filed

FEB 22 1922

JOSEPH W. KRAUTER

Burial Permit Class

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 19, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 16, 1922, to Feb. 19, 1922.

that I last saw him alive on Feb. 18, 1922

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH\* was as follows:

apoplexy

Carcinoma of liver +  
Bowels (duration) yrs. 6 mos. 1 ds.

CONTRIBUTORY Carcinoma of  
(Secondary) Liver (duration) yrs. 6 mos. 17 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. W. Kennard, M. D.

2-10-22 Address 708 Emerson St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Int. Culver Cemetery Feb 22 1922

20 UNDERTAKER

ADDRESS

Clement Hall 909 Hillen St



D 61563

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61563

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1915 E. Biddle* ST.)WARD) *8*

REGISTERED No. C

## 2-FULL NAME

*Jessie B. Glaser*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1915 E. Biddle*)St.; yrs., mos. ds.) *8*

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *col.* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*  
(Write the word.)

## 6-DATE OF BIRTH,

(Month) (Day) (Year) *1*

## 7-AGE,

*33* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work *House Work*  
(b) General nature of industry, business, or establishment in which employed (or employer) *House Work*9-BIRTHPLACE,  
(State or Country).*Born in Va*  
*live in Baltimore 8 years*

## 10-NAME OF FATHER,

*Walter Spangana*11-BIRTHPLACE OF FATHER  
(State or Country).*Born in Va*

## 12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER  
(State or Country).*Unknown*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Tom Johnson*(Address) *1915 E. Biddle St.*

## 15-

FEB 22 1922 ROBERT R. KRAUTER,  
Burial Permit Registrar.

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Feb 19*, *1922*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an...  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said...  
(Inquest, au-topsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Pneumonia Septicemia*  
(Duration) yrs. mos. ds. *4*CONTRIBUTORY  
(Secondary)(Signed) *J. R. G. G. G.* M. D.  
(Coroner) *2-20-22*  
(Address) *1915 E. Biddle St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

## Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Laural Cemetery*

## DATE OF BURIAL,

*Feb 22, 1922*

## 20-UNDERTAKER

*Mrs Robert Elliott*

## ADDRESS

*1725 Ashland Ave*WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61564 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61564

CERTIFICATE OF DEATH.

1-PLACE OF DEATH  
CITY OF BALTIMORE (No. 1915 E. Biddle ST. 8 WARD)  
2-FULL NAME Baby Johnson  
(Residence in Baltimore: No. 1915 E. Biddle St.; yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE, Col. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Bay (Write the word.)  
6-DATE OF BIRTH, Feb 12, 1922 (Month) (Day) (Year)  
7-AGE, 7 yrs. mos. ds. 10 LESS than 1 day, hrs. or min.  
8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, Iron Baby  
(b) General nature of industry, business, or establishment in which employed (or employer), Baby

9-BIRTHPLACE, (State or Country), in Baltimore City

10-NAME OF FATHER, Tom Johnson  
11-BIRTHPLACE OF FATHER (State or Country), Va  
12-MAIDEN NAME OF MOTHER, Jessie B. Johnson  
13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) Tom Johnson  
(Address) 1915 E. Biddle

15-ROBERT R. KRAUTER,  
Filed FEB 22 1922 191 Burlat Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 19, 1922 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, au-

and that said deceased came to death topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

Premature birth

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) J. H. Biddle (Copied) D. 2-20-22 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery DATE OF BURIAL, Feb. 22, 1922

20-UNDERTAKER, Mrs. Robert A. Elliott ADDRESS 1725 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61565

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1825 Ramsey

ST., 19 WARD)

### 2-FULL NAME

Katie L. O'Brien

(a) RESIDENCE NO. 1825 Ramsey

ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John L. O'Brien

6 DATE OF BIRTH (month, day, and year)

Nov. 22nd 1871

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5 yrs. 2 mo. 29 days

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Work.

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

John J. Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

South Carolina

12 MAIDEN NAME OF MOTHER

Harriette Powell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md.

14

Informant (Address)

John L. O'Brien 1825 Ramsey St.

15

FEB 22 1922

ROBERT R. KRAUTER,

Burial Permit

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1922, to February 20, 22, that I last saw her alive on Feb. 20 7, 1922,

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH\* was as follows:

apoplexy  
Carcinoma of Breast  
Blood Poison (duration) yrs. 6 mos. 2 ds.  
CONTRIBUTORY Carcinoma of Breast (Secondary) (duration) yrs. 6 mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. W. H. M. D.

(Address) 708 Euseb St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park Cem. Feb. 23 1922

20 UNDERTAKER

John J. Field

ADDRESS

W. Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 61566

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hollins Ferry Rd & Annapolis Ave.* ST. *101* WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ys.

mos.

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Widow*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

*Charles Hammond*

6 DATE OF BIRTH (month, day, and year)

*Oct 30<sup>th</sup> 1864*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*87*

*8*

*18*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*House keeper*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Emanuel Hall.*

9 BIRTHPLACE (city or town) (State or country)

*Germany*

10 NAME OF FATHER

*Jacob Graup*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Unknown*

14

Informant

(Address)

*Emanuel Hall*

15

File

*FEB 22 1922*

ROBERT M. KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 20* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 18*, 19 *22*, to *Feb 20*, 19 *22*.

that I last saw her alive on *Feb 20*, 19 *22*.

and that death occurred, on the date stated above, at *9 56* *A*. m.

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*

(duration) yrs. mos. *3* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Yes*

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

*Samuel Hoag*, M. D. *Feb 20 1922* (Address) *7296 Centre Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Cemetery*

*Feb 22 1922*

20 UNDERTAKER

*John J. Fields*

ADDRESS

*W. Lombard*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61567

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2000 Mt Royal Ave ST. 13 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 2000 Mt. Royal Ave St. 13 yrs. 15 mos. 15 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE,

White

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

## 6-DATE OF BIRTH,

Feb 14, 1874

(Month)

(Day)

(Year)

## 7-AGE,

67 yrs. 1 mos. 15 ds.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country).

## 10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country).

## 12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country).

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

FEB 22 1922

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Feb 20, 1922

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Feb 17, 1922, to Feb 20, 1922,

that I saw her alive on Feb 20, 1922,

and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH\* was as follows:

Intermittent hyperphosphatemia

chronic

(Duration) 1 yrs. 1 mos. 15 ds.

## CONTRIBUTORY

(Secondary)

Removal of appendix

(Duration) 4 yrs. 1 mos. 15 ds.

(Signed) H. V. J. Thomas

Feb 22, 1922 (Address) 1017 Cathedral St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Friend Cemetery

## DATE OF BURIAL,

Feb 22, 1922

## 20-UNDERTAKER

Geo. E. Sparch

## ADDRESS

307 Madison Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE, 61568

D 61568

## CERTIFICATE OF DEATH

1-PLACE OF DEATH *Smith Belts General Hospital*

REGISTERED NO.

CITY OF BALTIMORE: (No. *1213 Light* ST. *7* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Ledie C. Baxter*(a) RESIDENCE. NO. *2009 Eastern Ave* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*George Baxter*6 DATE OF BIRTH (month, day, and year) *July 19, 1881*7 AGE Years *40* Months *7* Days *0* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*10 NAME OF FATHER *George W. Robinson*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Baltimore Md.*12 MAIDEN NAME OF MOTHER *Rose Stokes*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Baltimore Md.*

## PARENTS

14 Informant *Clifford Baxter*(Address) *2009 Eastern Ave*15 Filed *FEB 22 1922* ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 19 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Feb. 19 1922* to *Feb. 19 1922*that I last saw her alive on *Feb. 19 1922*and that death occurred, on the date stated above, at *7 P. m.*

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*(duration) yrs. *1* mos. ds.CONTRIBUTORY *Pyopneumo Thorax*

(Secondary)

(duration) yrs. mos. *14* ds.

18 Where was disease contracted if not at place of death?

*At home*Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Samuel H. Wilson*, M. D.19 (Address) *Smith Belts Gen Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Baltimore Cemetery**Feb. 22 1922*

20 UNDERTAKER

*H. Sander Son*

ADDRESS

*1710 West H.*

NOTE—WRITE REASON, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61569

61569

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1736 Division* ST. *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *1736 Division* St. *90* yrs., — mos. — da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE. *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Widowed*  
(Write the word.)6-DATE OF BIRTH. *March 23*, 18*99*  
(Month) (Day) (Year)7-AGE, *92* yrs., *10* mos., *28* da. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *OOD*  
(b) General nature of industry, business, or establishment in which employed (or employer). *Housekeeper*9-BIRTHPLACE, (State or Country) *Balto Co Md*10-NAME OF FATHER, *Equilla Scott*11-BIRTHPLACE OF FATHER, (State or Country), *Md*12-MAIDEN NAME OF MOTHER *Priscilla Allen*13-BIRTHPLACE OF MOTHER, (State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Bond*(Address) *1736 Division*

15-FEB 22 1922 ROBERT R. KRAUTER, Registrar

Filed. *191* Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb. 19*, 19*22*  
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *Feb. 16* 19*22* to *Feb. 19* 19*22*, that I saw him alive on *Feb 18* 19*22*, and that death occurred, on the date stated above, at *2* m.

The CAUSE OF DEATH\* was as follows:

*General Arterio-sclerosis*CONTRIBUTORY (Secondary) *Senile debility*Signed) *W. J. Carr, Jr. M. D.*  
*Feb. 17, 1922* (Address) *515 W. 1st St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

*St. Johns Evangelical Church* *Feb. 22, 1922*

20-UNDERTAKER ADDRESS

*George H. Holland* *1631 Conduit Ave*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

✓  
ORE  
47

D 61570

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 416 N Kenwood ST. WARD)

2-FULL NAME Laure C. Simon

(a) RESIDENCE NO. 466 N Kenwood ST., Ar WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 24 yrs. 0 mos. 0 ds.

## MEDICAL CERTIFICATE OF DEATH

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
-------	-----------------	--

5a. If married, widowed, or divorced

HUSBAND of  
(or) WIFE of *Samuel L. Jones*

6 DATE OF BIRTH (month, day, and year) *Aug 16 / 1873*

7 AGE	48	Years	Months	Days	If LESS than 1 day, hrs or min.
			6	5	

16 DATE OF DEATH (month, day, and year) Feb 10 1922

I HEREBY CERTIFY, That I attended deceased from  
Oct 10, 1921, to Feb. 20, 1922

that I last saw him alive on 11 18 1922

and that death occurred, on the date stated above, at 70 m

The CAUSE OF DEATH\* was as follows:

Carcinoma of breast

(a) Trade, profession or particular kind of work..... House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Maryland*  
(State or country)

10 NAME OF FATHER *Francis Duncan*

II BIRTHPLACE OF FATHER (city or town).....  
(State or country) *Massachusetts*

12 MAIDEN-NAME OF MOTHER W. J. B. B. B.

13 BIRTHPLACE OF MOTHER (city or town) .....  
(State or country) *Massachusetts*

14 Informant Samuel Lomms  
(Address) 416 N. Kenwood

15  
Filed. FEB 22 1922 ROBERT R. KRAUTER.

(duration) 2 yrs mos ds

CONTRIBUTORY  
(Secondary) \_\_\_\_\_

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted  
If not at place of death? *Home*

Did an operation precede death? Yes Date of Oct 1960

Was there an autopsy? no

What test confirmed diagnosis? *Chucol*

(Signed) W. C. Cramer, M. D.

7/22, 1922 (Address) 2600 E. Buellch

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-	DATE OF BURIAL
MONTELEONE	

APPROVAL  
[Signature]

<b>UNDERTAKER</b>	<b>ADDRESS</b>
-------------------	----------------

Mrs. L. K. Miller 2334 1/2



Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61571

CERTIFICATE OF DEATH.

101-001  
D 61571

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 — W. 21<sup>st</sup> ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Robert Johnson

(a) RESIDENCE. NO.

120 — W. 21<sup>st</sup>

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single Married, Widowed, or Divorced (write the word)

Male Color Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept. 3-1920

7 AGE Years Months Days

1 5 18

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Chas Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

MD

12 MAIDEN NAME OF MOTHER

Mary Barker

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

MD

14

Informant (Address)

Chas Johnson, 120 W. 21<sup>st</sup>

15

Filed

FEB 22 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/2/1922

17

I HEREBY CERTIFY, That I attended deceased from

2/20, 1922, to 2/2/1922

that I last saw him alive on 2/20-1922

and that death occurred, on the date stated above, at 1:30 A. M.

The CAUSE OF DEATH\* was as follows:

Ac. Complication of Lung (1<sup>st</sup> Stage of Pneumonia)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. R. L. Latta, M. D.

19 (Address) 2137 Dunbar Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Samuel Cow. Feb 23 1922

20 UNDERTAKER

ADDRESS

Samuel Henderson, 518

D 61572

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1825 Vine

ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

James H. Franklin

## (a) RESIDENCE NO.

1825 Vine

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced (write the word)

married

## 5a If married, widowed, or divorced

HUSBAND of

Emma Franklin

## 6 DATE OF BIRTH (month, day, and year)

Feb. 14-1863

## 7 AGE

69

Years

Months

Days

If LESS than 1 day, hrs. or min.

5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Dry labor

(c) Name of employer

Different people

## 9 BIRTHPLACE (city or town) (State or country)

West River Md.

## 10 NAME OF FATHER

Edgar Franklin

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Not known

## 12 MAIDEN NAME OF MOTHER

Not known

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Not known

## 14

Informant (Address)

Emma Franklin 1825 Vine St.

## 15

FEB 22 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb. 19- 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb. 12, 1922, to Feb. 19, 1922.

that I last saw him alive on Feb. 18, 1922.

and that death occurred, on the date stated above, at 9-50 A. M.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos. 9 ds.

## CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas. T. McLaughlin, M. D.

19 (Address) 406 N. Street, N.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

National Ave. Feb. 21, 1922

## 20 UNDERTAKER

## ADDRESS

Samuel Newby 378 W. Biddle St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61573

## CERTIFICATE OF DEATH

D 61573

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1403 Bruce ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Frank Addison

(a) RESIDENCE. NO. 1403 Bruce ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. ~ mos. ~ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

male negro married  
6a If married, widowed, or divorced  
HUSBAND of Carrie Addison  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Day labourer 840

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Addison

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Maryland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Mike Addison  
11634 Penna Ave.

15

Filed

FEB 22 1922

ROBERT E. REAGAN

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 17 1922 to Feb. 18 1922

that I last saw him alive on Feb. 18 1922

and that death occurred, on the date stated above, at 1:25 p. m.

The CAUSE OF DEATH\* was as follows:

Chronic interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical signs, symptoms, urinary analysis

(Signed) John E. J. Campbell M. D.

, 19 (Address) 1405 Mount

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn

Feb 22 1922

20 UNDERTAKER

ADDRESS

Edmund Ringgold 1403 N. Carey

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

61574

52D 61574

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 882 N. Fayette St. 18 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Francis R. Bokman

## (a) RESIDENCE. No.

882 N. Fayette St.

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Ely. E. Bokman

## 6 DATE OF BIRTH (month, day, and year)

Aug 19<sup>th</sup> - 1850

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired Paper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

## 10 NAME OF FATHER

August C. Bokman

## PARENTS

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Hanover

## 12 MAIDEN NAME OF MOTHER

Mary A. Bokman

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

## 14

Informant (Address)

Geo. F. Bokman 882 N. Fayette St.

## 15

FEB 22 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 19<sup>th</sup> 1922, to Feb 21, 1922, that I last saw him alive on Feb 21, 1922,

and that death occurred, on the date stated above, at 5 A. M.

The CAUSE OF DEATH\* was as follows:

Chronic Rheumatism Artic. Mitral Regurgitation

(duration) yrs. mos. 3 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt. J. Murray, M. D.

Feb 22 1922 (Address) 510 N. Fremont Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

St Peters

## DATE OF BURIAL

2-24-1922

## 20 UNDERTAKER

H. B. Cunningham &amp; Son Schroeder St



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 10 ST. 2 WARD)

2-FULL NAME

(a) RESIDENCE. NO.

Length of residence in city or town where death occurred

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 21 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed FEB 22 1922 ROBERT K. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20<sup>th</sup> 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan. 31<sup>st</sup> 1922 to Feb. 20<sup>th</sup> 1922, that I last saw him alive on Feb. 20<sup>th</sup> 1922, and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH\* was as follows:

Acute Infection Endocarditis  
(Gonorrheal?)  
Coronary insufficiency

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Autopsy(Signed) Francis R. Drenth, M. D.70-20, 1922 Address Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore CemeteryFeb 23 1922

20 UNDERTAKER

ADDRESS

H. Hughes 424 N. Broadway

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61576

## CERTIFICATE OF DEATH.

31

D 61576

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 836 Calhoun Road St.; 16 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 836 Calhoun Road St.; 36 yrs., 4 mos., 24 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)6-DATE OF BIRTH, Sept 26th 1885 (Month) (Day) (Year)7-AGE, 36 yrs., 4 mos., 24 ds. If LESS than 1 day, .... hrs. or .... min.8-OCCUPATION: (a) Trade, profession, or particular kind of work, Spicer's Bakery (b) General nature of industry, business, or establishment in which employed (or employer), Schmidt9-BIRTHPLACE, (State or Country), Balto. md10-NAME OF FATHER, Henry Tice11-BIRTHPLACE OF FATHER (State or Country), Balto. md12-MAIDEN NAME OF MOTHER, Mary Tice13-BIRTHPLACE OF MOTHER (State or Country), Balto. md

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Jessie Tice(Address), 2867 N. Lenoir St

FEB 22 1922

ROBERT R. KRAUTER,

Filed..... 191.....

Burial Permit Check Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 20, 1922 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Nov 21 1921, to Feb 20 1922 that I saw him alive on Feb 19 1922 and that death occurred, on the date stated above, at 6:30 m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis (Duration) 1 yrs., 1 mos., 1 ds.CONTRIBUTORY (Secondary) (Duration) 1 yrs., 1 mos., 1 ds.(Signed) John S. Thacker, M. D. Feb 20, 1922 (Address) 1219 N. Lenoir St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

Western Cemetery Feb 22 1922

20-UNDERTAKER ADDRESS

R. D. Shippert 2236 Fred St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61577

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2528 Foster Ave

ST. 1 WARD)

## 2-FULL NAME

Mary Shaner

## (a) RESIDENCE. No.

2528 Foster Ave

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

78 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Widowed

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

John M. Shaner

## 6 DATE OF BIRTH (month, day, and year)

March 15-1892

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

79

11

6

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Balto C.  
Md.

## 10 NAME OF FATHER

Ernest Roberts

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Not known

## 14

Informant  
(Address)John P. Shaner  
2528 Foster Ave

## 15

FEB 22 1922

ROBERT A. KROGER  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21 1922

## 17

I HEREBY CERTIFY, That I attended deceased from  
Feb 18 1922 to Feb 20 1922  
that I last saw alive on Feb 20 1922

and that death occurred, on the date stated above, at 8:15 A m.

The CAUSE OF DEATH\* was as follows:

Exhaustion  
(duration) 3 mos. 3 ds.  
CONTRIBUTORY Chronic Bronchitis,  
(Secondary) Dnt yrs. mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Schwartz

Feb 23 1922

## 20 UNDERTAKER

## ADDRESS

Zirkler &amp; Zirkler

1739  
Eager

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(See Affidavit over)  
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61578

CERTIFICATE OF DEATH

MAR 6 - 1922

D 61578

1-PLACE OF DEATH *Nicola Del. Zingaro*  
CITY OF BALTIMORE: (No. *312 S. High St.* ST., *5* WARD)  
2-FULL NAME *Nicholas Del. Zingo*  
(a) RESIDENCE NO. *312 S. High St.* ST., *5* WARD  
(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred *12* yrs. mos. ds. How long in U. S., if of foreign birth? *12* yrs. mos. ds.

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*  
5a If married, widowed, or divorced HUSBAND of *Maria Del. Zingaro* (or) WIFE of *Mary Del. Zingo*  
6 DATE OF BIRTH (month, day, and year) *Dec 22 1873*  
7 AGE *49* Years *3* Months *28* Days (If LESS than 1 day, hrs. or min.) *28*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Black 006*  
(b) General nature of industry, business, or establishment in which employed (or employer) *Smith*  
(c) Name of employer

9 BIRTHPLACE (city or town) *Italy* (State or country) *Riccia Province of Campobasso*

10 NAME OF FATHER *Nicola Del. Zingo*

11 BIRTHPLACE OF FATHER (city or town) *Italy* (State or country) *Province of Campobasso*

12 MAIDEN NAME OF MOTHER *Mary Del. Zingo*

13 BIRTHPLACE OF MOTHER (city or town) *Italy* (State or country) *Province of Campobasso*

14 Informant *Mary Del. Zingo* (Address) *312 S. High St.*

15 *FEB 22 1922* ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 21 1922*

17 I HEREBY CERTIFY, That I attended deceased from *May*, 19*21* to *Feb. 20*, 19*22*, that I last saw him alive on *Feb 20*, 19*22*, and that death occurred, on the date stated above, at *6:30* p. m.

The CAUSE OF DEATH\* was as follows:

*Cancer of the penis*

(duration) yrs. mos. ds.

CONTRIBUTORY *Malnutrition in the groin* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *May 11* 19*20*

Was there an autopsy? *No*

What test confirmed diagnosis? *Microscopic examination of sections*

(Signed) *M. V. A. Williams* M. D.

1976 N. Rutland St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Most Holy Redeemer*

*Feb 23 1922*

20 UNDERTAKER

ADDRESS

*Wendell Kipp from 57 E. Pratt St.*



State of Maryland,

to wit:

D 61578

BE IT REMEMBERED, That on this

4<sup>th</sup>

day of

March

A. D. 1922, before me, the subscriber, a

Notary Public

of the said State, in and for the

City of Baltimore

aforesaid, personally appeared

M. S. Koppelman

and made oath in due form of law that

the name of Nicolas Del Zingro  
appearing on the transcripts of the records of deaths in  
the city of Baltimore dated March 1<sup>st</sup> 1922 was mispelled  
and is in correct and should appear Nicola Del Zingero

M. S. Koppelman Not.

Sworn before me this 4<sup>th</sup> day of March 1922

Harry Charkatz

Notary Public

MAR 6 - 1922

D 61578

Nicola Del Zingaro, son of Michael of Vincenza Grsso  
born in Riccia, Province of Campobasso, Italy, Born on October  
23, 1872, died in Baltimore, February 21, 1922 of Abdominal  
Cancer. He is married to Maria Poca, daughter of Antonio.

Personally appeared before me this 17th day of July  
1922 and made affidavit that the aforesaid is true to the  
best of his knowledge and belief.

G. Schiappino  
Royal Italian Consular Agent.  
417 E Baltimore St

Reed Gaultier  
Notary. per E. G. G.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61579

REGISTERED No. C

D 61579

1-PLACE OF DEATH  
CITY OF BALTIMORE (No. St. Agnes Hospital ST. 19 WARD)  
2-FULL NAME Benjamin Franklin Moxley  
(Residence in Baltimore: No. 223 S. Calhoun St. St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male  
4-COLOR OR RACE, White  
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married  
(Write the word.)  
6-DATE OF BIRTH, October 19<sup>th</sup> 1886, / .....  
(Month) (Day) (Year)  
7-AGE, 35 yrs. 4 mos. 1 ds. If LESS than 1 day, .... hrs. or .... min.  
8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. Material Man  
(b) General nature of industry, business, or establishment in which employed (or employer). Mt. Clare Shop B. and O. P. R.  
9-BIRTHPLACE, (State or Country), Baltimore, Md.

### PARENTS.

10-NAME OF FATHER, Charles Moxley  
11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.  
12-MAIDEN NAME OF MOTHER, Lotta Sheppard  
13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.  
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) Mrs. May Moxley  
(Address) 223 S. Calhoun St.

15- FEB 22 1922 ROBERT R. KRAUTER,  
Filed. 191. Burial Permit Clerk.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 20<sup>th</sup> 1922, 191...  
(Month) (Day) (Year)  
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
Fracture of Skull  
Steam R.R. accident  
(Duration) yrs. mos. 2 ds.  
CONTRIBUTORY (Secondary) .....  
(Duration) yrs. mos. ds.  
(Signed) James M. Fulton M. D.  
Feb. 21<sup>st</sup> 1922 (Coroner.)  
(Address) 700 E. Chase

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).  
At place of death, St Agnes Hospital yrs. mos. ds. 1 mo. 1 ds.  
Where was disease contracted, if not at place of death? Randome, Md.  
Former or usual residence 223 S. Calhoun

19-PLACE OF BURIAL OR REMOVAL. Louisa Park Cem. DATE OF BURIAL, Feb. 24<sup>th</sup> 1922  
20-UNDERTAKER, Joseph B. Cook ADDRESS 1003 N. Baltimore

D 61580

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61580

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1126 Leadenhall St. ST., 23 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Sill

(a) RESIDENCE NO. 1126 Leadenhall St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 18 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 18<sup>th</sup> 1832

7 AGE Years 89 Months 7 Days 3 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Rising Sun, Cecil Co. Md. (State or country)

10 NAME OF FATHER Mathew Weir

11 BIRTHPLACE OF FATHER (city or town) Cecil Co. Md. (State or country)

12 MAIDEN NAME OF MOTHER Eliza Gima

13 BIRTHPLACE OF MOTHER (city or town) Cecil Co. Md. (State or country)

14 Informant Gardon G. Sill 1126 Leadenhall St. (Address)

15 FEB 22 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20<sup>th</sup> 192217 I HEREBY CERTIFY, That I attended deceased from Nov. 10<sup>th</sup> 1922, to Feb. 20<sup>th</sup> 1922,that I last saw her alive on Feb. 20<sup>th</sup> 1922,

and that death occurred, on the date stated above, at 5.50 P. m.

The CAUSE OF DEATH\* was as follows:

Old age.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. E. Simpson M. D. Feb. 21<sup>st</sup> 1922 (Address) 910 Light St.

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR CREMATION DATE OF BURIAL, Feb. 23, 1922

Columbia - Ind. 1003 N. Calhoun St.

20 UNDERTAKER Joseph B. Cook ADDRESS



**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Chr. nephritis.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61581

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61581

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 105 N Center St. 5 Ward)

Registered No. C.....

2-FULL NAME

(Residence in Baltimore: No. 105 N Center St. St.; 7 yrs., ..... mos. .... ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-Single, Unknown  
Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, UK  
(Month) (Day) (Year)

7-AGE, 35 yrs. .... mos. .... ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, Baker  
(b) General nature of industry, business, or establishment in which employed (or employer), 003

9-BIRTHPLACE, (State or Country), Unknown

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. M. Levin

(Address) 816 Air Quality St.

15- FEB 22 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 18  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Myocardial Infarction

(Duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Broken Coronary Arteries

(Duration) ..... yrs. .... mos. .... ds.

(Signed) W. H. B. B. B. M. D.  
(Coroner.)

192 (Address) 1127 E

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, ..... yrs. .... mos. .... ds. In the State, ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence, .....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Trinity Amity Feb 22 1922

20-UNDER TAKER, ADDRESS 1127 E

S. Harrison Balto St

61582

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61582

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *121 N. Potomac* ST. *6* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mary Fretzner*(a) RESIDENCE. No. *121 N. Potomac* ST. *6* WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred *51* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Tobias Fretzner*6 DATE OF BIRTH (month, day, and year) *March 30 1849*7 AGE Years *72* Months *10* Days *20* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Wine*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *George Schreiner*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Not known*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Not known*14 Informant *Mrs. Bieri* (Address) *221 N. Potomac St.*

15 FEB 22 1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 20 1922*17 I HEREBY CERTIFY, That I attended deceased from *Feb 9 1922* to *Feb 20 1922*that I last saw her alive on *Feb 20 1922*and that death occurred, on the date stated above, at *7:30 P. m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*CONTRIBUTORY (Secondary) *Endocarditis* yrs. mos. *9* ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *John T. Quinn* M. D.(Address) *35-a Potomac St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Schwartz's Cemetery* DATE OF BURIAL *Feb 23 1922*

20 UNDERTAKER

*Henry Lutz* ADDRESS *1203 N. Broadway*

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. — 1-10-21 — M&T — 1500 Bks.

61583

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 619 N. Linwood Ave ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Frisino

(a) RESIDENCE NO. 619 N. Linwood Ave ST. 7 WARD

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Antonette Frisino

6 DATE OF BIRTH (month, day, and year) Dec 1<sup>st</sup> 1885

7 AGE Years 36 Months 2 Days 17 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. B. Club

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER Rayton Frisino

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosa Bella

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Joseph Frisino (Address) 619 N. Linwood Ave

15 FEB 22 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1922

17 HEREBY CERTIFY, That I attended deceased from Feb 19 1922 to Feb 20 1922

that I last saw him alive on Feb 20 1922

and that death occurred, on the date stated above, at 8:35 P m.

The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis

CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Leach M. D.

(Address) 413 B Washington

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Holy Redemer Feb 23 1922  
Geo. S. Brook North Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61584

## CERTIFICATE OF DEATH.

D 61584

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Bellevue Hospital*)ST.: *5* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. *921 N. Central Ave.*

(Usual place of abode)

ST.: *14th*WARD. *14th*

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *1 yr.* mos. ds.How long in U. S., if of foreign birth? *1 yr.* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Jan. 30-1922*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. *22*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto*10 NAME OF FATHER *Louis Kraut*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Russia*12 MAIDEN NAME OF MOTHER *Mollie*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Russia*

14

Informant (Address) *1411 E. Balto*

15

FEB 22 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 22 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Feb. 19 1922* to *Feb. 19 1922*that I last saw him alive on *Feb. 19 1922*and that death occurred, on the date stated above, at *9 A. M.*

The CAUSE OF DEATH\* was as follows:

*Bronch. Pneumonia, Klebsiella*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *Pneumonia*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *W. Baylin*, M. D.2/22/1922 (Address) *210 S. 1st St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Bellevue Wash. Rd.**2-22 1922*

20 UNDERTAKER

ADDRESS

*Jack Lewis, 1411 E. Balto*

Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 S Stricku St.; 161 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 305 S Stricku St.; ..... yrs., ..... mos. .... ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Male

## 4-COLOR OR RACE

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

## 6-DATE OF BIRTH

Feb 21, 1922  
(Month) (Day) (Year)

## 7-AGE

..... yrs. .... mos. .... ds.

If LESS than 1 day,  
..... hrs. or 10 min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

## 9-BIRTHPLACE, (State or Country),

Baltimore MD

## 10-NAME OF FATHER,

Anthony B Costello

## 11-BIRTHPLACE OF FATHER (State or Country),

Washington D.C.

## 12-MAIDEN NAME OF MOTHER

Mary J Sinclair

## 13-BIRTHPLACE OF MOTHER (State or Country),

Balto MD

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Anthony B Costello

(Address)

305 S Stricku

## 15-

Filed FEB 23 1922

ROBERT R. KRAUTER,

Serial Permit

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Feb 21, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Feb 21 1922, to Feb 21 1922,that I saw him alive on Feb 21 1922,and that death occurred, on the date stated above, at 4:20 p. m.

The CAUSE OF DEATH\* was as follows:

Premature Birth  
7 1/2 months  
10 minutes  
(Duration) ..... yrs. .... mos. .... ds.

## CONTRIBUTORY (Secondary)

(Signed) W. E. Miller M. D.  
Feb 21, 1922 (Address) 1520 Hollins

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

St Peters Cem Feb 22, 1922

## 20-UNDERTAKER

H. H. Witzke 13126 Lombard

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

*Frank Bonkowski*  
HEALTH DEPARTMENT—CITY OF BALTIMORE

31

D 61587

D 61587

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. *Municipal Tuberculosis Hospital* WARD *2*)

2-FULL NAME *Frank Bonkowski*

(a) RESIDENCE. No. *810 E. Pratt st.* ST. *Unknown* WARD. *Unknown*  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred *Unknown* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

16 DATE OF DEATH (month, day, and year) *Feb. 20, 1922*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

17 I HEREBY CERTIFY. That i attended deceased from *Nov. 4, 1920* to *Feb. 20, 1922*. that I last saw him alive on *Feb. 20, 1922*. and that death occurred, on the date stated above, at *9.30 a. m.* The CAUSE OF DEATH\* was as follows:

6 DATE OF BIRTH (month, day, and year) *1900* 7 AGE Years Months Days If LESS than 1 day. hrs. or min. *21*

*Pulmonary tuberculosis*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer*

(duration) *2* yrs. *1* mos. ds.

(b) General nature of industry, business, or establishment in which employed (or employer) *Unknown*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(c) Name of employer *Unknown*

18 Where was disease contracted if not at place of death? *Unknown*

9 BIRTHPLACE (city or town). (State or country) *Maryland*

Did an operation precede death? *NO* Date of

10 NAME OF FATHER *Geo. Bonkowski*

Was there an autopsy?

11 BIRTHPLACE OF FATHER (city or town). (State or country) *Poland*

What test confirmed diagnosis? *T.B. in sputum, X-ray*

12 MAIDEN NAME OF MOTHER *Unknown*

(Signed) *Francis L. Dada* 2-20-22 Address *Municipal Tbc. Hospital*

13 BIRTHPLACE OF MOTHER (city or town). (State or country) *Poland*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant *Hospital Records* (Address) *M.T.H.*

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

15 *FEB 23 1922* *ROBERT R. KRAUTER* Registrar Burial Permit Clerk

*Polish Rosary* *Feb 23 1922* 20 UNDERTAKER *Lohn m Weber* ADDRESS *1803 Bank St*



MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 61588 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 D 61588

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1028 Leodenhall ST. 23 WARD)

2-FULL NAME Annie Bell Fisher

(a) RESIDENCE, No. 1028 Leodenhall ST. 23 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED No. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 36 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Housework 070 (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) MA (State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Annie J. Bennett (Address) 1009 Leadenhall St.

15 FEB 23 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21/1922

17 HEREBY CERTIFY, That I attended deceased from 2/9/22 to 2/21/22 that I last saw him alive on 2/21/22 and that death occurred, on the date stated above at 2:00 P. M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

CE Phlebitis

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. 7

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. H. B. M. D. (Address) 908 N. Sharp St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel St DATE OF BURIAL Feb 23 1922

20 UNDERTAKER J. H. B. M. D. ADDRESS 108 W. Market

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 61589

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 61589

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 Archer ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Malinda Glasgow

(a) RESIDENCE. NO. 621 Archer ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE Years 77 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond Co Va (State or country)

10 NAME OF FATHER Joseph Black

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant H. Dove (Address) 621 Archer St

15 Filed FEB 23 1922 ROBERT A. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21/22

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1922, to Feb 21, 1922, that I last saw him alive on Feb 21, 1922, and that death occurred, on the date stated above, at 79 m. The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia, (duration) yrs. mos. 7 ds.

CONTRIBUTORY Bronchitis (Secondary) (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? (Signed) Hyland & Dran M. D. (Address) 1527 Columbia

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Auburn Ct Feb 27 1922

20 UNDERTAKER ADDRESS

L. L. & Thomas's Son 1816 Monty

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1808 Ashland Ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1808 Ashland Ave St.; yrs., 1 mo., 4 da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Male

## 4-COLOR OR RACE

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

## 6-DATE OF BIRTH

Jan. 16, 1922  
(Month) (Day) (Year)

## 7-AGE

1 yrs., 4 mos., 4 da.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

## 9-BIRTHPLACE, (State or Country).

Balto. Md

## 10-NAME OF FATHER

John R. Matysch

## 11-BIRTHPLACE OF FATHER (State or Country)

Bohemia

## 12-MAIDEN NAME OF MOTHER

Agnes Finck

## 13-BIRTHPLACE OF MOTHER (State or Country)

Bohemia

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John R. Matysch  
1808 Ashland Ave.  
(Address)

## 15-

Filed FEB 23 1922

ROBERT R. KRAUTER,

Burial Permit 10054

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

Feb. 21, 1922  
(Month) (Day) (Year)

## 17-I, HEREBY CERTIFY, That I attended deceased from

Feb. 16 1922, to Feb. 21 1922that I saw him alive on Feb. 21 1922and that death occurred, on the date stated above, at 100 m.

The CAUSE OF DEATH\* was as follows:

Primate Birth

(Duration).....yrs.....mos.....da.

CONTRIBUTORY.....  
(Secondary)

(Duration).....yrs.....mos.....da.

(Signed) Will J. Kraut M. D.Feb. 23, 1922 (Address) 801 N. E. St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

St. RedeemerFeb. 23, 1922

## 20-UNDERTAKER

## ADDRESS

Frank Loachson1808 Ashland Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(over)  
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61591

CERTIFICATE OF DEATH.

X 188 D 61591

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *University Hospital* ST.; WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Henry Beck Townshend*

(a) RESIDENCE. NO. *Chestertown, Md.* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *2* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *child-*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Nov. 30, 1913*

7 AGE *8* Years *2* Months *22* Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Child (schoolboy)*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Chestertown Md.* (State or country)

10 NAME OF FATHER *Sidney P. Townshend*

11 BIRTHPLACE OF FATHER (city or town) *Prince George Co. Md.* (State or country)

12 MAIDEN NAME OF MOTHER *Fannie Evans*

13 BIRTHPLACE OF MOTHER (city or town) *Queen Anne Co. Md.* (State or country)

14 Informant *Hospital Records* (Address)

15 Filed *FEB 23 1922* Registrar *LLY*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 22, 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Feb. 20, 1922*, to *Feb. 22, 1922*, that I last saw him live on *Feb. 22, 1922*, and that death occurred, on the date stated above, at *10:35 p.m.*

The CAUSE OF DEATH\* was as follows:

*Meningitis*

(duration) yrs. mos. ds.

CONTRIBUTORY *Fractured skull* (Secondary)

(duration) yrs. mos. *6* ds.

18 Where was disease contracted if not at place of death? *Chestertown Md.*

Did an operation precede death? *Yes* Date of *Feb. 20, 1922*

Was there an autopsy? *No.*

What test confirmed diagnosis? *Examination*

(Signed) *Wm. J. Horne*, M. D.

, 19 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Chestertown Md.* *Feb 23 1922*

20 UNDERTAKER ADDRESS

*Harry W. Witzke* *1531 W. Lombard*



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

On Feb 17, 1922 while  
coasting at his home Chateaufort  
Md he received an injury to  
skull. He was operated at this  
hospital on Feb 20, 1922. A fracture  
of base of skull was found with  
a localized abscess in right temporal  
region. He also had a cerebrospinal  
meningitis. Cyrus D. Kamm M.D.

D 61592

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 4922 Hayford Road ST. 27 WARD)

## 2-FULL NAME

Lawrence E. Busch

## (a) RESIDENCE. No.

4922 Hayford Road

ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Child

## 6 DATE OF BIRTH (month, day, and year)

9/6/21

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

5

15

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore Md.

## 10 NAME OF FATHER

John Busch

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Baltimore Md.

## 12 MAIDEN NAME OF MOTHER

Alice Armstrong

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Baltimore Md.

## 14

Informant  
(Address)John Busch  
4922 Hayford Road

## 15

File

FEB 23 1922

ROBERT R. KRAUTER  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb 21 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb 18 1922, to Feb 21 1922

that I last saw him alive on Feb 21 1922

and that death occurred, on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH\* was as follows:

Exhaustion &amp; T. pneumonia

(duration) yrs. mos. da.

CONTRIBUTORY  
(Secondary)

Broncho Pneumonia

(duration) yrs. mos. da.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Clara J. Mian M. D.

Address

4706 Hayford Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

New Cathedral Cem.

9/23/21

## 20 UNDERTAKER

## ADDRESS

George J. Futh 1735 Hayford Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 61593 HEALTH DEPARTMENT - CITY OF BALTIMORE

D 61593

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO

Mercy Hospital 17

ST.: WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs. Ella Gray

(a) RESIDENCE. NO.

2131 N. Calvert

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

18 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Joseph Claggett Gray

6 DATE OF BIRTH (month, day, and year)

Sept. 3, 1838

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

66

5

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

at home

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

George Stonebraker

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Mary Claggett

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Jennie E Stonebraker 2131 N Calvert St

15

FEB 23 1922

ROBERT R. KRAUTER,

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 21 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 5, 1921 to Feb. 21, 1922.

that I last saw her alive on Feb. 21, 1922.

and that death occurred, on the date stated above, at 2:06 a.m.

The CAUSE OF DEATH\* was as follows:

Malignant Papilloma of ovary. (Inoperable)

CONTRIBUTORY (Secondary)

Backache & Pains in legs

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death?

Laboratory Examinations Date of Feb 2, 1922

Was there an autopsy?

no

What test confirmed diagnosis?

Pathology Signs & Symptoms

(Signed)

John J. Cowan M. D.

19 (Address)

Mercy Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Landon Park

Feb 23 1922

20 UNDERTAKER

ADDRESS

Shu O Mitchell 1201 W. Fayette

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61594

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 20 E Franklin ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nettie Culbert Hopewell

(a) RESIDENCE NO. 20 E Franklin St.

WARD.

(Usual place of residence)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug. 1858

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

63

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Household duties

(b) General nature of industry, business, or establishment in which employed (or employer)

ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

St Mary Co MD

10 NAME OF FATHER

Joseph R. Hopewell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

St Mary Co MD

12 MAIDEN NAME OF MOTHER

Mama A. Culbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

MD

14

Informant

(Address)

Hawell Warner 108 Fayette St

15

Filed

FEB 23 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 21 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 21, 1922, to Feb 21, 1922

that I last saw her alive on Feb 21, 1922

and that death occurred, on the date stated above, at 2 00 m.

The CAUSE OF DEATH\* was as follows:

Cerebral apoplexy (duration) yrs. mos.

CONTRIBUTORY (Secondary)

Don't know (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Place of death

Did an operation precede death?

no

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Garrison, M. D.

222 1922 Address 117 N. Venable St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

David Ridge Cemetery

Feb 23 1922

20 UNDERTAKER

ADDRESS

John Mitchell 1201 N. Fayette St



N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

61595

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 61595  
REGISTERED No. C

1-PLACE OF DEATH  
CITY OF BALTIMORE (No. 2107 Linden Ave ST. 13 WARD)  
2-FULL NAME David H. Lauchheimer  
(Residence in Baltimore: No. 2210 Eutan Place St.; yrs. Lifespan ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male	4-COLOR OR RACE White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single
6-DATE OF BIRTH April 8th, 1865 (Month) (Day) (Year)		
7-AGE 56 yrs. 10 mos. 11 ds. If LESS than 1 day, ... hrs. or ... min.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work... Retired (b) General nature of industry, business, or establishment in which employed (or employer)... Clothing Mfg.		
9-BIRTHPLACE (State or Country)... Balt Md		
PARENTS.	10-NAME OF FATHER... H. H. Lauchheimer	
	11-BIRTHPLACE OF FATHER (State or Country)... Germany	
	12-MAIDEN NAME OF MOTHER... Barthe Eichler	
	13-BIRTHPLACE OF MOTHER (State or Country)... Germany	

CORONER'S CERTIFICATE OF DEATH.

14-DATE OF DEATH, Feb 21st, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
Apoplexy  
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Signed) J. M. H. ... M. D.  
Feb 22, 1922 Address 13632 Roland Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).  
At place of death ... yrs. ... mos. ... ds. In the ... yrs. ... mos. ... ds.  
Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Ches Shalom Cem	DATE OF BURIAL 2/23/22
20-UNDERTAKER David Bonheim	ADDRESS 118 M W 100 Bay St

FEB 23 1922

ROBERT R. KRAUTER,  
Burial Permit Clerk.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61596

## CERTIFICATE OF DEATH.

129 D 61596

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2028 E. Lafayette Ave. 8

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 2028 E. Lafayette Ave

St.; 50 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female. 4-COLOR OR RACE. White 5-STATUS. MARRIED. married (If widower, use word.)

6-DATE OF BIRTH. September 8, 1857 (Month) (Day) (Year)

7-AGE. 64 yrs., 5 mos., 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Housework. (b) General nature of industry, business, or establishment in which employed (or employer). 037

9-BIRTHPLACE, (State or Country) Bavaria Germany

10-NAME OF FATHER. Gunther

11-BIRTHPLACE OF FATHER (State or Country) Bavaria Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Bavaria Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry M. Kaiser

(Address) 1600 E. Andrew Ave.

15- FEB 23 1922 191. ROBERT R. KRAUTER, Burial Permit

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. February 21, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 29, 1921 to February 21, 1922, that I saw her alive on February 21, 1922, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY. Uraemia &amp; exhaustion (Secondary)

(Duration) yrs. mos. ds.

(Signed) Albert C. Brown M. D.

Feb 22, 1922 (Address) 2027 E. North Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Larkwood Cemetery 2/24/1922

20-UNDERTAKER ADDRESS

C. J. Fanning &amp; Son 2027 E. Lafayette Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61597

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 N. Washington ST.: 8-WARD)

## 2-FULL NAME

Mary E. Chetelat

## (a) RESIDENCE

No. 1806 N. WashingtonST.: 8-WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Chas. W. Chetelat

## 6 DATE OF BIRTH (month, day, and year)

Feb. 22 - 1922

## 7 AGE

Years

Months

Days

If LESS than 1 day, — hrs. or 20 min.

200

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

None

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

## 10 NAME OF FATHER

Chas. W. Chetelat

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto.Maryland

## 12 MAIDEN NAME OF MOTHER

Edna F. Chetelat

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

MertonBaltimore, Md.

## 14

Informant

Edwin B. Fenby

(Address)

1223 N. Caroline St.

## 15

Filed

FEB 23 1922ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22 - 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb. 22, 1922, to Feb. 22, 1922that I last saw her alive on Feb. 22, 1922and that death occurred, on the date stated above, at 3:05 P. M.

The CAUSE OF DEATH\* was as follows:

Injury to brain from difficult birth

(duration)

yrs.

mos.

ds.

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? None(Signed) Edwin B. Fenby, M. D.Address 1223 N. Caroline St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Holy Redeemer CemeteryFeb. 23 1922

## 20 UNDERTAKER

## ADDRESS

E. J. Hanning & Son - 1938 E. Lafayette Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.





## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61599 CERTIFICATE OF DEATH:

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST.: 19 WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Fnd

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 24<sup>th</sup>, 1921, to Feb. 17<sup>th</sup>, 1922, that I last saw him alive on Feb. 17<sup>th</sup>, 1922,

and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis, pulmonary

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Norace G. Stewart, M. D.

17, 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

FEB 21 1922

20 UNDERTAKER

ADDRESS

Commissioner Health.

W. W. WOODALL

66

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61600

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1359 N. Stricker* ST. *15* WARD)

REGISTERED NO. C

## 2-FULL NAME

(Residence in Baltimore: No. *1359 N. Stricker* St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Male*

## 4-COLOR OR RACE

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*

## 6-DATE OF BIRTH,

*not known 1862*  
(Month) (Day) (Year)

## 7-AGE

*60*

If LESS than 1 day, ....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Farmer 986*  
*Retired*

## 9-BIRTHPLACE, (State or Country),

*md*

## PARENTS.

## 10-NAME OF FATHER,

*Lewis Thompson*

## 11-BIRTHPLACE OF FATHER (State or Country),

*md*

## 12-MAIDEN NAME OF MOTHER

*Mahalia Oliver*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*md*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

Filed

*FEB 23 1922*

Registrar

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Feb 20<sup>th</sup>, 1922*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Feb 19 1922, to Feb 21 1922,*that I saw him alive on *Feb 20 1922,*and that death occurred, on the date stated above, at *9:30 a. m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*

(Duration).... yrs. .... mos. .... ds.

CONTRIBUTORY, (Secondary) *Senile Debility*

(Duration).... yrs. .... mos. .... ds.

(Signed) *Harry J. Brown* M. D.*Feb 22 1922* (Address) *1501 Presb'n*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. .... mos. .... ds. In the State yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*St. Ambrose* *Feb 24 1922*

## 20-UNDERTAKER

## ADDRESS

*Edw. J. Carey* *1501 Presb'n*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61601

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-001  
D 61601

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *St Agnes Hospital* St., *21* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *809 Scott* St.; yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *white* 5-Single, Married, Widowed, or Divorced, *Married*  
(Write the word.)

6-DATE OF BIRTH, *July 8* 18*65*  
(Month) (Day) (Year)

7-AGE, *58* yrs. *7* mos. *11* ds. If LESS than 1 day, .....hrs. or.....min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *Machinist*  
(b) General nature of industry, business, or establishment in which employed (or employer), *Mittlere Shop*

9-BIRTHPLACE, (State or Country), *Balt me*

PARENTS.  
10-NAME OF FATHER, *George Melvin*  
11-BIRTHPLACE OF FATHER, (State or Country), *Balt city*  
12-MAIDEN NAME OF MOTHER, *Virginia Field*  
13-BIRTHPLACE OF MOTHER, (State or Country), *Balt me*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant), *Charles E. Melvin*  
(Address), *809 Scott St.*

15-*FEB 23 1922*  
Registrar, *L. G.*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb 20* 19*22*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Investigation*  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Investigation* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH\* was as follows:  
*Both legs crushed by baby, when steam R.R. accident*

(Duration).....yrs.....mos. *2* hrs. *45* min.  
CONTRIBUTORY (Secondary) *Marriage from*  
(Duration).....yrs.....mos. *2* yrs. *4* mos. *10* ds.  
(Signed), *James M. Gibson* M. D.  
(Coroner.)  
*Feb 21, 1922* (Address) *740 E. Chas St*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).  
At place of death,.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?  
*Landed over me*  
Former or usual residence, *809 Scott St*

19-PLACE OF BURIAL OR REMOVAL, *London Park* DATE OF BURIAL, *Feb 23, 1922*

20-UNDERTAKER, *Wm. J. Pickens & Son* ADDRESS, *North & Pa*

D 61602

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 D 61602

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 Barclay ST., 11 WARD)

## 2-FULL NAME

Thomas J. Madden

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1124 Barclay

ST.

WARD

(Usual place of abode)

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 5 mos. 18 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced, HUSBAND of Rose V. Madden (or) WIFE of6 DATE OF BIRTH (month, day, and year) Sept 3 18757 AGE Years 46 Months 5 Days 18 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Foreman for

(b) General nature of industry, business, or establishment in which employed (or employer)

Kingman Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md10 NAME OF FATHER Patrick Madden11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)12 MAIDEN NAME OF MOTHER Catherine O'Neil13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

## 14

Informant Mr. Rose V. Madden (Address) 1124 Barclay St.

## 15

3261 22 031

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 2 192217 I HEREBY CERTIFY, That I attended deceased from Nov 5 1921 to Feb 2 1922, that I last saw him alive on Feb 19 1922, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis(duration) 8 yrs. 7 mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) 4 yrs. 4 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Examination of sputum(Signed) W. J. Saunders M. D.19 (Address) 219 E. Preston

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

New Cathedral Cemetery Feb 25 1922  
Henry Brock & Son 1301 E. Coyle

N. B. WRITING INSTRUCTIONS: PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



D 61603

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

2-FULL NAME

(a) RESIDENCE. NO. \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred \_\_\_\_\_

How long in U. S., if of foreign birth? \_\_\_\_\_

WARD) \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

(or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

FEB 23 1922

ROBERT R. KRAUTER

Burial Permit Clerk,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 18<sup>th</sup>, 1922, to Feb. 19<sup>th</sup>, 1922,that I last saw her alive on Feb. 19<sup>th</sup>, 1922,

and that death occurred, on the date stated above, at 8:15 P. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

CONTRIBUTORY (Secondary)

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of \_\_\_\_\_

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) E. S. Sidman, M. D.

, 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park. Feb. 23 1922

20 UNDERTAKER

George H. Schwab 201 E. Pratt St.

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Not of tuberculous  
nature. Cause of  
abscess unknown. No  
further history.*

D 61604

HEALTH DEPARTMENT—CITY OF BALTIMORE D 61604

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 N Greene ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 422 N. Greene St.; 1 yrs., 4 mos., ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE,

White

## 5-SINGLE,

MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

(Month) July (Day) 19 (Year) 1922

## 7-AGE,

1 yrs., 7 mos., 2 ds.

## If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,  
(State or Country),

Baltimore

## 10-NAME OF FATHER,

Rosario Gaffi

11-BIRTHPLACE OF FATHER  
(State or Country),

Italy

## 12-MAIDEN NAME OF MOTHER

Rose Gaffi

13-BIRTHPLACE OF MOTHER  
(State or Country),

Italy

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Gaffi

(Address) 422 N. Greene St.

## 15-

Filed

FEB 23 1922

J. W. Vehm

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Feb 22, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Feb 10, 1922, to Feb 22, 1922,

that I saw her alive on Feb 21, 1922,

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY. Pneumonia  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Frank M. Guernon M. D.

Feb 22, 1922 (Address) 322 N. Greene St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Cathedralbury

## DATE OF BURIAL,

Feb 23, 1922

## 20-UNDERTAKER

W. M. Routon

## ADDRESS

230 N. Greene

Every item of information should be carefully supplied. AGE should be given EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61605

D 61605

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1901 Edgewood ST.; 15 WARD)

## 2-FULL NAME

Albert J. Shackelford(Residence in Baltimore: No. 1901 Edgewood St.; 30 yrs., 30 mos., 30 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE,

White

## 5-SINGLE,

Married  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

## 6-DATE OF BIRTH,

Oct. 23<sup>rd</sup>, 1844  
(Month) (Day) (Year)

## 7-AGE,

77 yrs., 3 mos., 29 ds.

If LESS than 1 day,

...hrs. or ...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

Carpenter9-BIRTHPLACE,  
(State or Country),Virginia

## 10-NAME OF FATHER,

Zachariah Shackelford11-BIRTHPLACE OF FATHER  
(State or Country),Virginia

## 12-MAIDEN NAME OF MOTHER

Fanny Brew13-BIRTHPLACE OF MOTHER  
(State or Country),Virginia

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. R. Stackhouse(Address) 1901 Edgewood Plr.

FEB 23 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Feb. 22<sup>nd</sup>, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Feb. 16<sup>th</sup>, 1922, to Feb. 21<sup>st</sup>, 1922,that I saw him alive on Feb. 21<sup>st</sup>, 1922,and that death occurred, on the date stated above, at 12.30<sup>pm</sup>.

The CAUSE OF DEATH\* was as follows:

Arteriosclerosis(Duration) 5 yrs., 5 mos., 5 ds.CONTRIBUTORY  
(Secondary)Angina Pectoris(Duration) 5 yrs., 5 mos., 5 ds.(Signed) Isaac B. Dickson M. D.Feb. 22<sup>nd</sup>, 1922 (Address) 3055 W. North Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

## 20-UNDERTAKER

## ADDRESS



*John O. Rice*  
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61606

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. Veterans Hospital #56

REGISTERED NO.

CITY OF BALTIMORE: (No. *24* Ft. Mc Henry Baltimore, Md. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Rice, John Oliver*(a) RESIDENCE NO. *Booke, Md.*

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Single*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Unknown*

6 DATE OF BIRTH (month, day, and year)

*Unknown*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*21**-**-*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Farmer*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)*Unknown*

(c) Name of employer

*Unknown*9 BIRTHPLACE (city or town)  
(State or country)*Md.*

10 NAME OF FATHER

*Unknown*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Unknown*

12 MAIDEN NAME OF MOTHER

*Unknown*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Unknown*

14

Informant *E.T. Rosenbreck*  
(Address) *Registrar*

15

*ROBERT R. KRAUTER,**FEB 23 1922*

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/22/22* 19

17

I HEREBY CERTIFY, That I attended deceased from

*Feb. 21* 19 *22* to *Feb. 22* 19 *22*that I last saw him alive on *Feb. 22* 19 *22*,and that death occurred, on the date stated above, at *7.00 P.m.*

The CAUSE OF DEATH\* was as follows:

*Tuberculosis chronic pulmonary far advanced  
& active**Unknown*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)*Unknown*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?*Unknown*

Did an operation precede death?

*No*

Date of

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Clinical*

(Signed)

*F. N. Gordon*  
*Surgeon (R)*  
19 (Address) *Ft. McHenry, Md.*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*Arnolds Station A. A. Co Md.**Feb 24 1922*

20 UNDERTAKER

ADDRESS

*Taylor & Sons**Annapolis Md.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61608

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 16 WARD)

## 2-FULL NAME

George Rodifer Speaks Jr.

(a) RESIDENCE. NO.

1620 Mosher

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Mollie Speaks.

6 DATE OF BIRTH (month, day, and year)

February 16, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

General labor.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Charleston Maryland

10 NAME OF FATHER

George B. Speaks

11 BIRTHPLACE OF FATHER (city or town) (State or country)

St. Marys County

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Charleston Maryland

14

Informant (Address)

William P. Speaks 1309 N. Street

15

FEB 23 1922

ROBERT R. KRAUTER,

Registrar Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 20 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 16, 1922, to Feb. 20, 1922,

that I last saw him alive on Feb. 19, 1922,

and that death occurred, on the date stated above, at 1.30 P. M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

At place of death

Did an operation precede death?

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

General symptoms

(Signed)

Charles E. Clark

M. D.

1922. 1922 (Address)

1306 W. Gilmor St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Edward Ringgold

1465 1/2 J.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Hks.

D 61609 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1203 Cleveland* ST. *21* WARD)

2-FULL NAME

*Vincenzo Ferretti*

(a) RESIDENCE. No. *1203 Cleveland* ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Nov. 15, 1855*

7 AGE

*66* Years *3* Months *6* Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Italy*

10 NAME OF FATHER

*Michele Ferretti*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Italy*

12 MAIDEN NAME OF MOTHER

*Costanza Ferretti*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Italy*

14

Informant (Address)

*Antonio Ferretti 1203 Cleveland St.*

15

Filed

*FEB 23 1922*

*Settlem*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2-21-1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 14, 1922, to Feb 21, 1922*

that I last saw him alive on *Feb 21, 1922*

and that death occurred, on the date stated above, at *9:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*

(duration) yrs. mos. *3* ds.

CONTRIBUTORY (Secondary)

*Hypertension*

(duration) yrs. mos. *3* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Dr. R. D. Damm* M. D.

, 19 (Address)

*1007 Calverton*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Redeemer Cemetery*

*Feb 24 1922*

20 UNDERTAKER

ADDRESS

*George J. Rutz 1735 Maryland Ave.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61610  
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 Mosher ST.; 16 WARD)

2-FULL NAME

Henry E. Schoenewolf

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1801 Mosher St.; 62 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

Married

6-DATE OF BIRTH,

Sept 4, 1869  
(Month) (Day) (Year)

7-AGE,

55 yrs., mos. ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,  
(State or Country),

Baltimore Md.

10-NAME OF FATHER,

C. F. Schoenewolf

11-BIRTHPLACE OF FATHER  
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Christina Chocch

13-BIRTHPLACE OF MOTHER  
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Schoenewolf

(Address) 1801 Mosher St.

15-

FEB 23 1922

Filed..... 191.....

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

2 22, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Feb 17, 1922, to Feb 22, 1922,

that I saw him alive on Feb 21, 1922

and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY  
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) E. Urban Smith M. D.

Feb 22, 1922 (Address) 517 Park Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the..... yrs..... mos..... ds. State.....

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Woodlawn Cemetery Feb 23, 1922

20-UNDERTAKER

John Mitchell 1301 N. Broadway

DATE OF BURIAL,

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 17 WARD)

2-FULL NAME

Elsie Hairston

(a) RESIDENCE. NO.

1140 Druid Hill St. E

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

unknown

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced,

HUSBAND of  
(or) WIFE ofAdams Hairston

6 DATE OF BIRTH (month, day, and year)

May 17 - 88

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.37

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Virginia

10 NAME OF FATHER

Stephen Dawson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Gertrude Hill

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia

14

Informant  
(Address)JOHNS HOPKINS HOSPITALRecords

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18<sup>th</sup> 1922

17

I HEREBY CERTIFY, That I attended deceased from

Dec. 19<sup>th</sup> 1921, to Feb. 18<sup>th</sup> 1922that I last saw him alive on Feb. 8<sup>th</sup> 1922and that death occurred, on the date stated above, at 4<sup>30</sup> A.M.

The CAUSE OF DEATH\* was as follows:

Premature Separation of Placenta  
& External & Concealed Haemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)Nephritic Toxaemia

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?YesDid an operation precede death? Yes Date of Feb 18<sup>th</sup> 22Was there an autopsy? NoWhat test confirmed diagnosis? Operation showed findings(Signed) J. C. Carroll M. D., 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Richmond Co Va

DATE OF BURIAL

Feb 24 1922

20 UNDERTAKER

Mrs Robert A Elliott

ADDRESS

1726- Ashland StEB 23 1922 Burial Permit 4181

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT - CITY OF BALTIMORE

D 61612

## CERTIFICATE OF DEATH.

61612

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 Barnes ST., 7 WARD)2-FULL NAME Isabelle Banks(a) RESIDENCE NO. 1718 Barnes  
(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female ColoredMarried5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofWife

6 DATE OF BIRTH (month, day, and year)

7 AGE

44 Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

House Wife

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Born in Baltimore

10 NAME OF FATHER

John Williams

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Born in Baltimore

12 MAIDEN NAME OF MOTHER

Indecent Lent

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ohio

14

Informant  
(Address)Tom Banks  
1718 Barnes St.

15

Filed

19

Registrar

Partial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-20-1922

17

I HEREBY CERTIFY, That I attended deceased from  
5-9- 1921, to 2-20- 1922.that I last saw her alive on 2-20- 1922.and that death occurred, on the date stated above, at 5:45 P. m.

The CAUSE OF DEATH\* was as follows:

Valvulitis

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Gargill M. D.2-22, 1922 (Address) 611 N. Caroline

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Ashbury Cemetery

DATE OF BURIAL

Feb 24, 1922

20 UNDERTAKER

Mrs Robert A ElliottADDRESS 1725Ashland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

EB 23 1922

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN

*No further history than  
Chronic valvulitis.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61613

## CERTIFICATE OF DEATH.

D 61613

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 546 W. Preston St ST. 17 WARD)

## 2-FULL NAME

Francis Scott

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

546 W. Preston

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female ColoredMarried5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofWife

6 DATE OF BIRTH (month, day, and year)

March 1881

7 AGE

41

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Work 037

(b) General nature of industry, business, or establishment in which employed (or employer)

House Work

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore City

10 NAME OF FATHER

Thomas Scott

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore City

12 MAIDEN NAME OF MOTHER

Charlotte Brown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Lawrence Ind

14

Informant

Mary Scott

(Address)

546 W. Preston St

15

Filed

Robert D. Harrison

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 22, 1922

17

HEREBY CERTIFY, That I attended deceased from

Feb. 14, 1921, to Feb. 22, 1922.that I last saw her alive on Feb. 21, 1922.and that death occurred, on the date stated above, at 3 A. M.

The CAUSE OF DEATH\* was as follows:

ApoplexyGangrene Carcinoma of Rectum

(duration) yrs. mos. ds.

CONTRIBUTORY Carcinoma of Rectum

(Secondary)

Gangrene (duration) yrs. mos. ds.If Where was disease contracted  
if not at place of death?Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

L. G. K. M. M. D.

2-23-22 (Address)

708 E. 2nd St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Int. Aurlon CoFeb 26, 1922

20 UNDERTAKER

ADDRESS

Mrs R A ElliottAshland Ave

Physicians should state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61614

## CERTIFICATE OF DEATH.

100-001 D 61614  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1006 N. Stricker* ST. *16* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *1006 N. Stricker* St.: ... yrs., ... mos. ... da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Female*

## 4-COLOR OR RACE,

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Baby*

## 6-DATE OF BIRTH,

*July 2<sup>nd</sup>, 1921*  
(Month) (Day) (Year)

## 7-AGE,

*Now 7* yrs. *20* mos. ... da.

If LESS than 1 day, ... hrs. or ... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Baby for*  
(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE, (State or Country),

*Balto, Md*

## 10-NAME OF FATHER,

*Wm Moore*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Md*

## 12-MAIDEN NAME OF MOTHER

*Iva Grayson*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Md*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Iva Moore*(Address) *1006 N. Stricker*

## 15-

FEB 23 1922 Robert P. Harrison  
Registrar.

Burial Permit 61614

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Feb 22<sup>nd</sup>, 1922*  
(Month) (Day) (Year)

## 17-I HEREBY CERTIFY, That I attended deceased from

*Feb 21 1922*, to *Feb 22 1922*,  
that I saw her alive on *Feb 22<sup>nd</sup> 1922*,  
and that death occurred, on the date stated above, at *11:30 A* m.

The CAUSE OF DEATH\* was as follows:

*Acute Broncho-Pneumonia*(Duration) ... yrs. ... mos. *2* ... da.

## CONTRIBUTORY (Secondary)

*Acute Bronchitis*(Duration) ... yrs. ... mos. *7* ... da.(Signed) *Harry F. Brown* M. D.*Feb 23<sup>rd</sup> 1922* (Address) *1501 Presbiterian St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Mt-Auburn Cem*

## DATE OF BURIAL,

*Feb 24<sup>th</sup>, 1922*

## 20-UNDERTAKER

*Mrs Robert A. Elliot*

## ADDRESS

*1726*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61615

D 61615

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE (NO. 329. S. 13<sup>th</sup> ST. 76 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

(a) RESIDENCE NO. 329. S. 13<sup>th</sup> ST. 76 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced. (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 29-1843

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

79

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Jerome

10 NAME OF FATHER

Ant / 1111

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Jerome

12 MAIDEN NAME OF MOTHER

Dora / 1111

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

329 S. 13<sup>th</sup> St

15

Robert P. Harrison

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 21 1922I HEREBY CERTIFY, That I attended deceased from Feb 8 1922 to Feb 21 1922that I last saw him alive on Feb 19 1922and that death occurred, on the date stated above, at 76 m.

The CAUSE OF DEATH\* was as follows:

Chronic Endocarditis  
(Valvular defect.)

(duration) yrs. mos. ds.

CONTRIBUTORY Dilated heart

(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical signs(Signed) W. M. A. 1922 M. D.1922 (Address) 329 S. Ellwood St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Paul's Church July 24 1922

20 UNDERTAKER

ADDRESS

Robert P. Harrison 329 S. 13<sup>th</sup> St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B 23 1922

Serial Permit 0111





D 61617

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61617

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *179* ST. *9* WARD)2-FULL NAME *Mrs. Laura B. Bryant*(a) RESIDENCE, NO. *514 E. 27th St.* ST. *9* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *15* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, Divorced (write the word) *Married*5a If married, widowed, or divorced, HUSBAND or (or) WIFE of *Lewis B. Bryant*

6 DATE OF BIRTH (month, day, and year)

7 AGE Years *48* Months *11* Days *22* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Md.*10 NAME OF FATHER *Edward Chalk*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md.*12 MAIDEN NAME OF MOTHER *Mary M. Wilcox*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*14 Informant (Address) *Lewis B. Bryant*  
*514 E. 27th St.*15 *Robert V. Harrison*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 19 22*17 I HEREBY CERTIFY, That I attended deceased from *2/16/22* to *2/24/22* that I last saw him alive on *2/22/22* and that death occurred, on the date stated above, at *4:30 p.m.* The CAUSE OF DEATH\* was as follows:  
*Acute Cor. Ar. Dist.*

CONTRIBUTORY (duration) yrs. mos. ds.

*Chronic Pyelitis* (duration) *3* yrs. mos. ds.

18 Where was disease contracted? If not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? *Cerebral findings*(Signed) *John T. Harrison* M. D.19 (Address) *721 E. North St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.

DATE OF BURIAL

*Laura M. Bryant* *2/25/22*

20 UNDERTAKER

ADDRESS

*Hughman Cook* *502 E. North St.*

Physicians should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

22 1922

Serial Permit 11111



## HEALTH DEPARTMENT—CITY OF BALTIMORE

1922

D 61619

61619

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_ ST.; \_\_\_\_\_ WARD)

REGISTERED NO. C \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. \_\_\_\_\_ St.; \_\_\_\_\_ yrs., \_\_\_\_\_ mos., \_\_\_\_\_ ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH, *April 5, 1860.*  
(Month) (Day) (Year)

7-AGE, *62* yrs., \_\_\_\_\_ mos., \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *Marine*  
(b) General nature of industry, business, or establishment in which employed (or employer). *Callor*

9-BIRTHPLACE, (State or Country), *Maryland*

10-NAME OF FATHER, *George Fields*

11-BIRTHPLACE OF FATHER (State or Country) *Somerset to Md.*

12-MAIDEN NAME OF MOTHER *Mary Kibble*

13-BIRTHPLACE OF MOTHER (State or Country) *Somerset to Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. W. Fields*(Address) *928 N. Mount*

15- \_\_\_\_\_

Robert P. Harrison

191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb 23, 1922*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Jan 1922* to *Feb 23 1922*, that I saw him alive on *Feb 6, 1922*, and that death occurred, on the date stated above, at *8 A. m.*

The CAUSE OF DEATH\* was as follows:

*Epithelioma of Floor of mouth*  
(Duration) \_\_\_\_\_ yrs., \_\_\_\_\_ mos., \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary) *Ascaris*

(Duration) \_\_\_\_\_ yrs., \_\_\_\_\_ mos., \_\_\_\_\_ ds.

(Signed) *Ralph A. Hoyt* M. D.

\_\_\_\_\_, 191... (Address) *262 Chestnut St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death \_\_\_\_\_ yrs., \_\_\_\_\_ mos., \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs., \_\_\_\_\_ mos., \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? *At Home*

Former or usual residence *928 N. Mount*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

*Catsburg Md.* *2/27, 1922*

20-UNDERTAKER ADDRESS

*William Cook* *502 E North*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

B 23 1922

B- WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EXAMINING PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 61620 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1632 N Wolfe ST., 8 WARD)

2-FULL NAME

Joseph Martin Kuhn

(a) RESIDENCE NO.

1632 N Wolfe

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 1 1/2 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 11-1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

Jan

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Joseph H. Kuhn

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

(State or country)

MD

12 MAIDEN NAME OF MOTHER

Margaret J. Grey

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

(State or country)

MD

14

Informant (Address)

Mrs Margaret J. Kuhn  
1632 N Wolfe St

15

Robert F. Harrison,

19

Permit Clerk,

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 18, 1922, to Feb 23, 1922, that I last saw him alive on Feb 22, 1922,

and that death occurred, on the date stated above, at 1240 a m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Clinical

(Signed) R. B. Carman, M. D.

2023 1922 Address 1707 N Caroline St

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Redeemer

Feb 24 1922

20 UNDERTAKER

ADDRESS

Maxim W. E. Deffen

B 23 1922



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior.*

12- Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61621 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61621

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (N. *Mary Hospital* St. *4* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *David McQuarney*

(Residence in Baltimore: No. *Not known* St.; yrs. .... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *M* 4-COLOR OR RACE *W* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Single*

6-DATE OF BIRTH. .... 1. .... (Month) (Day) (Year)

7-AGE *50* *about* If LESS than 1 day, .... hrs. or .... min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. .... (b) General nature of industry, business, or establishment in which employed (or employer). ....

9-BIRTHPLACE, (State or Country), ....

PARENTS. 10-NAME OF FATHER, .... 11-BIRTHPLACE OF FATHER, (State or Country), .... 12-MAIDEN NAME OF MOTHER, .... 13-BIRTHPLACE OF MOTHER, (State or Country), ....

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) .... (Address) ....

15- *Robert P. Harrison* Registrar. Filed *23* 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb 6 - 22* (Month) (Day) (Year)

17- I HEREBY CERTIFY that I took charge of the remains described above, held a *inquiry* (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquiry* find that said deceased came to death on the day stated above. The CAUSE OF DEATH\* was as follows:

*Fracture of Skull* (Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) *Street* (Duration) .... yrs. .... mos. .... ds. (Signed) *W. C. S. Hades* M. D. (Coroner.) 1922 (Address) *123 W. May*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds. Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, *HOPKINS HOSPITAL* DATE OF BURIAL, *19* .....

20-ENDERTAKER, *Commissioner Health* ADDRESS *FEB 2 1922*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61622 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61622

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 20576 High St. 5 Ward)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 20576 High St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M 4-COLOR OR RACE Negro

6-DATE OF BIRTH Not known

7-AGE 62 about If LESS than 1 day, yrs. mos. ds. yrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Matchman (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Not known

PARENTS. 10-NAME OF FATHER, 11-BIRTHPLACE OF FATHER, (State or Country), 12-MAIDEN NAME OF MOTHER, 13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15- Robert P. Harrison

Filed 8 23 1922 Serial Permit 18948 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH 8 10 1922

17- I HEREBY CERTIFY that I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Suicide Gunshot wound

CONTRIBUTORY (Secondary)

(Signed) M. D. (Coroner.) 1922 (Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

HOPKINS HOSPITAL

20-UNDERTAKER, ADDRESS

Commissioner Health, FEB 2 1922

D 61623

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61623

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Woman's Hospital* ST.; *7* WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Miss Anna Danzeglock*(Residence in Baltimore: No. *1920 McElderry St* St.; *52* yrs., *4* mos., *15* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)6-DATE OF BIRTH, *Oct 7<sup>th</sup>*, *1869* (Month) (Day) (Year)7-AGE, *52* yrs., *4* mos., *15* ds. If LESS than 1 day, ....hrs. or....min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Housework* (b) General nature of industry, business, or establishment in which employed (or employer), *at home*9-BIRTHPLACE, (State or Country), *city*10-NAME OF FATHER, *Justus H. Danzeglock*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Elizabeth Vaupel*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Carloline H. Demmer*(Address) *Manchester Md*

15-

*Robert P. Harrison,*

Filed..... 191.....

FEB 23 1922

Burial Permit *61* Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb 22*, *1922* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan 23* 19*22*, to *Feb 22* 19*22*, that I saw her alive on *Feb 22* 19*22*, and that death occurred, on the date stated above, at *6<sup>5-8</sup>* m.

The CAUSE OF DEATH\* was as follows:

*Myocardial Insufficiency*(Duration) *3* yrs. ....mos. ....ds.CONTRIBUTORY *Secondary Anemia from bleeding* (Secondary) *fibroids*(Duration) *1* yrs. ....mos. ....ds.(Signed) *E. E. Duncan*, M. D.*2/22*, 19*22* (Address) *Woman's Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *1* mos. *15* ds. In the *52* yrs. *4* mos. *15* ds.Where was disease contracted, if not at place of death? *1920 McElderry St*Former or usual residence *1920 McElderry St*

19-PLACE OF BURIAL OR REMOVAL,

*McBarnet*

DATE OF BURIAL,

*Feb 25 1922*

20-UNDERTAKER

*Philip Herwig*ADDRESS *2016**Oldens*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificate.

D 61624 HEALTH DEPARTMENT—CITY OF BALTIMORE, 188, 003 D 61624

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,

Female

4-COLOR OR RACE,

White

5-Single,

Married, Widowed, or Divorced, (Write the word.)

Single

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

7-AGE,

40 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Domestic

Ms. Baton

9-BIRTHPLACE, (State or Country).

Ireland

10-NAME OF FATHER,

Ed. Howley

11-BIRTHPLACE OF FATHER, (State or Country).

Ireland

12-MAIDEN NAME OF MOTHER,

Delia Killeen

13-BIRTHPLACE OF MOTHER, (State or Country).

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. Walsh

(Address)

1039 Warden St.

15-

Robert F. Harrison,

Filed

192

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY that I took charge of the

remains described above, held as (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.)

find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH was as follows:

Auto Accident  
Fracture of Skull

CONTRIBUTORY (Secondary)

(Signed)

(Address)

\*State the Disease Causing Death, or, in deaths from Violent Cause, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

New Catholic

July 24, 1922

20-INTERTAKER.

ADDRESS

Henry C. M... ..

914

EB 23 1922

Burial Permit Clerk

*Op. by. Lewis Jones (L) -*

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges,*

*peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

*Abortion*, *Hemorrhage*, *Meningitis*, *Phlebitis*,  
*Cellulitis*, *Gangrene*, *Miscarriage*, *Pyemia*,  
*Childbirth*, *Gastritis*, *Necrosis*, *Septicemia*,  
*Convulsions*, *Erysipelas*, *Peritonitis*, *Tetanus*.

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61625

## CERTIFICATE OF DEATH.

114 D 61625  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 329 Bruce ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 329 Bruce St.; 8 yrs., 10 mos. 7 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Caucasian

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)  
Single

6-DATE OF BIRTH,

April 20, 1914  
(Month) (Day) (Year)

7-AGE,

8 yrs., 10 mos., 1 ds.

If LESS than 1 day,  
...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Schools

9-BIRTHPLACE,  
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert J. Harrison,

Registrar.

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Feb 21, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 19 1922, to Feb 21 1922

that I saw him alive on Feb 21 1922,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH\* was as follows:

Gastro Enteritis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY  
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

2-23, 1922 (Address) 104 W. Fayette St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

23 1922

D 61626

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61626

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Lombard &amp; Jones

ST.:

WARD)

2-FULL NAME

Mr. Alice Rhodes

(a) RESIDENCE. No.

Mld School for Boys Rock Raven

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

X yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Charles F. Rhodes

6 DATE OF BIRTH (month, day, and year)

Sept. 8<sup>th</sup> 1858

7 AGE

Years

Months

Days

LESS than

1 day, hrs.

or min.

63.

5

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Matron at Mld.

(b) General nature of industry, business, or establishment in which employed (or employer)

School for Boys

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Canada.

10 NAME OF FATHER

Robert Johnston

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

England

12 MAIDEN NAME OF MOTHER

Jane MacLain

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Scotland

14

Informant  
(Address)Mr. F. B. Whitten  
90 North St. Saco, Maine

15

Filed

Robert F. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

2/22 1922

17

I HEREBY CERTIFY, That I attended deceased from

2/22, 1922, to 2/22, 1922.

that I last saw him alive on 2/22, 1922.

and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency

(duration) 3 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

Bronchi pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted  
if not at place of death?

Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Clinical tests

(Signed)

Feb. 23<sup>rd</sup> 1922

(Address)

University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Saco, Maine

Feb. 24<sup>th</sup> 1922

20 UNDERTAKER

Joseph B. Cook

ADDRESS

103 N. Baltimore St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

B 23 1922



D 61627

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61627

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2614 N. Calvert ST. 12 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence L. O'Neill

(a) RESIDENCE. No. 2614 N. Calvert ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Elizabeth Smith

6 DATE OF BIRTH (month, day, and year) Jan. 18, 1888

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 34 1 4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Architect

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Michael F. O'Neill

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Katharine C. Hanson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Harry O'Neill (Address) 2614 N. Calvert St.

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22 1922

17

I HEREBY CERTIFY, That I attended Deceased from Feb. 20, 1922, to Feb. 22, 1922

that I last saw him alive on Feb. 21, 1922

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH\* was as follows:

Broncho-pneumonia

(duration) -- yrs. -- mos. 4 ds.

## CONTRIBUTORY (Secondary)

(duration) -- yrs. -- mos. -- ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Arthur H. Hillman, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Dread Ridge Cemetery

2/24, 1922

20 UNDERTAKER

ADDRESS

Henry W. Mears &amp; Son 805 N. Calvert

EB 23 1922

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61628

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Green &amp; Lombard St.

ST.

WARD)

2-FULL NAME

Edward Heil

(a) RESIDENCE. No.

1427 Woodall St.

ST.

WARD.

Horsely Md

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

1

mos.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 14, 21

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

10

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Dorsey, Md.

10 NAME OF FATHER

Phillip Heil

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Martha Smallwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Father Phillip Heil 1427 Woodall St

15

FILED

FEB 24 1922

ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 23

19 22

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 22, 19 22, to Feb. 23, 19 22,

that I last saw him alive on Feb 22, 19 22,

and that death occurred, on the date stated above, at 1:55 a.m.

The CAUSE OF DEATH\* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

1427 Woodall St

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) Geo. E. Wells, M. D.

19 (Address) Univ. Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery Feb 24 19 22

20 UNDERTAKER

ADDRESS

Knell &amp; Son 1729 H Pratt St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61629 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 61629

CERTIFICATE OF DEATH.

PLACE OF DEATH  
CITY OF BALTIMORE (No. 1108 LAW ST. 5 WARD)  
FULL NAME Ella M. Johnson  
(Residence in Baltimore: No. 1108 LAW ST.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE, Col. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Bay-  
6-DATE OF BIRTH Jan 10 1922 (Month) (Day) (Year)  
7-AGE, If LESS than 1 day, yrs. 1 mos. 18 da. ...hrs. or...min.?  
8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. Bay-  
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE.  
(State or Country). Balt

PARENTS.  
10-NAME OF FATHER John Johnson  
11-BIRTHPLACE OF FATHER (State or Country). W. Va.  
12-MAIDEN NAME OF MOTHER Martha Johnson  
13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Johnson  
(Address) 1108 LAW ST.

15-ROBERT R. KRAUTER,  
Filed FEB 24 1922 Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 23 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.)

And that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Brunch Poisoning  
(Duration) yrs. mos. da.

CONTRIBUTORY  
(Secondary)

(Signed) J. M. Taylor, M. D.  
(Coroner)

2-23, 1922 Address: 1108 LAW ST.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. da. In the State... yrs. mos. da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Feb 24 1922

20-UNDERTAKER, Mrs J. G. Locke ADDRESS 1302 Jefferson St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR- TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61630

## CERTIFICATE OF DEATH.

179 D 61630

### 1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 910 S. Sharp ST. 23 WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

John Henry Scott

(a) RESIDENCE. NO. 910 S. Sharp ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of Francis Scott

6 DATE OF BIRTH (month, day, and year) Apr. 1880

7 AGE Years 41 Months 10 Days If LESS than 1 day. hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

McCusker Poland Park Co

9 BIRTHPLACE (city or town) Queen Ann Co. Maryland.

10 NAME OF FATHER Charles Scott

11 BIRTHPLACE OF FATHER (city or town) Winchester Maryland.

12 MAIDEN NAME OF MOTHER Sallie Ann Wilson

13 BIRTHPLACE OF MOTHER (city or town) Queen Ann Co. Maryland.

14 Informant Francis Scott (Address) 910 S. Sharp St.

15 FEB 24 1922

ROBERT R. KRAUTER

Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/22 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb, 20 1922, to Feb, 22, 1922, that I last saw him alive on Feb, 22, 1922, and that death occurred, on the date stated above, at 2.30 P. m. The CAUSE OF DEATH\* was as follows:

Acute Pulmonary Deformity

CONTRIBUTORY (Secondary) Chr. Diffuse Nephritis and Arteriosclerosis (duration) yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinary, + H. pressure.

(Signed) Davis Francislin M. D.

(Address) 1224 See St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION & REMOVAL DATE OF BURIAL

Graville Mt. View Feb. 24 1922

20 UNDERTAKER

ADDRESS

J. H. Brown & Son 108 W. Mount St. M. D. V. R. R. — by way of Point to Graville



Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61631

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.

2-FULL NAME..

(Residence in Baltimore: No.

Registered No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH.

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER.

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

Filed

FEB 24 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereon and from the evidence obtained by said

And that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Asphyxiation by  
Inhalation of Gas  
Accident

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. Fulton M. D.

(Coroner)

Feb 24 1922 (Address) 2001 Chapel

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

London Park Ave Feb 24 1922

20-TAKEN BY

Address

John J. Lawan

101 Hollins St

D 61632

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

179 D 61632

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1708 McCulloh* ST.: *14* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Charlotte Cornish*(a) RESIDENCE. No. *1708 McCulloh* ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *48* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F*4 COLOR OR RACE *Colored*5 Single, Married, Widowed, or Divorced (write the word) *Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE

Years *48*

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *domestic*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Md.*10 NAME OF FATHER *Not known*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Not known*12 MAIDEN NAME OF MOTHER *Not known*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Not known*

14

Informant *Daniel Easton* (Address) *916 Penna av*

15

FEB 24 1922

ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 20* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from *February 14*, 19 *22*, to *February*, 19 *22*, that I last saw h *er* alive on *February 20*, 19 *22*.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

*Interstitial Nephritis*(duration) yrs. *7* mos. ds.CONTRIBUTORY *Uraemia* (Secondary)(duration) yrs. mos. ds. *20*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Urinalysis*(Signed) *H. S. McCord* M. D.7/21, 1922 (Address) *2005 D and Hill av*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mt Auburn av**Feb 24 1922*

20 UNDERTAKER

*Daniel Easton*ADDRESS *916**Penna*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61633

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1234 Division ST.; 17 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 1234 Division St.; unkn yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE,

col5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

## 6-DATE OF BIRTH,

unknown, 1 (Month) (Day) (Year)

## 7-AGE,

83 yrs., mos. ds.

If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Housework  
070

## 9-BIRTHPLACE, (State or Country),

Taylor Island  
Dorchester County Ind

## 10-NAME OF FATHER,

John Wesley Brooke

## 11-BIRTHPLACE OF FATHER (State or Country),

Taylor Island  
Dorchester County Ind

## 12-MAIDEN NAME OF MOTHER

unknown

## 13-BIRTHPLACE OF MOTHER (State or Country),

Taylor Island  
Dorchester County Ind

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. H. Hooper(Address) 406 W. Conway St

## 15-

FEB 24 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

July, 21, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 20 - 1922, to July 21 - 1922, that I saw h e alive on July 20 1922, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(Duration)..... yrs. .... mos. .... ds.

## CONTRIBUTORY (Secondary)

Advanced age

(Duration)..... yrs. .... mos. .... ds.

(Signed)..... M. D.

July 23, 1922 (Address) W. H. Hooper

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Dorchester County, 1922

## 20-UNDERTAKER

## ADDRESS

Mrs. E. H. Hooper 406 W. Conway St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61634

D 61634

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Cervan Hospital for Crippled Children

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE:

Hillsdale wa. ST. WARD)

2-FULL NAME

Ladson Boyle Jr.

(a) RESIDENCE

Sumter, S.C.

ST.

WARD.

Dumb St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

11

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1914

7 AGE

8

Years

Months

Days

If LESS than  
1 day, ....hrs.  
or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

School boy job

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Sumter, S.C.

10 NAME OF FATHER

Ladson Boyle

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

S.C.

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

S.C.

14

Informant

(Address)

19. Juneau Taylor and  
1102 N. Charles St.

FEB 24 1922

ROBERT K. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 23, 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 25, 1921, to Feb 23, 1922.

that I last saw him alive on Feb 22, 1922.

and that death occurred, on the date stated above, at 5:00 a.m.

The CAUSE OF DEATH\* was as follows:

Pott's Disease, Tubercular  
Ostitis of upper thoracic  
vertebrae

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)Mechanical Pressure of  
Tubercular Abscess on Trachea

(duration) yrs. mos. 1 1/2 ds.

18 Where was disease contracted  
if not at place of death?

South Carolina

Did an operation precede death?

No Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

Autopsy

(Signed) 19. Juneau Taylor, M. D.

, 19 (Address) 1102 N. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Sumpter S.C.

Feb 24 1922

20 UNDERTAKER

ADDRESS

Geo W Little

2705  
Edmondson

Physicians should state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

61635

61635

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

General Gayman Aged Home

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 70 E. Cor. Balto. Gayman ST.: 70 WARD)

2-FULL NAME

Carolina Louise Unterbeck

(a) RESIDENCE. NO.

N. E. Cor. Balto. Gayman ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 14, 1885

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

66

4

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Karl Unterbeck

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Louise Unterbeck

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Records of German Aged Home Baltimore Gayman St.

15

FEB 24 1922

ROBERT K. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 1922, to Feb. 22nd 1922,

that I last saw her alive on Feb. 22nd 1922,

and that death occurred, on the date stated above, at 11 A. M.

The CAUSE OF DEATH\* was as follows:

Organic Heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John H. Hoff, M. D.

Feb. 24 1922 (Address) 1243 W. Balto. St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Cemetery

Feb. 25 1922

20 UNDERTAKER

ADDRESS

C. B. Cook

1003 Balto. St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61636

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. *2841 W. Laval St.* 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

(Residence in Baltimore: No. *2841 W. Laval St.*)

St.; yrs., *71* mos. *5* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*male*

4-COLOR OR RACE,

*white*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *widow*

6-DATE OF BIRTH,

*August 30, 1850*  
(Month) (Day) (Year)

7-AGE,

*71 yrs., 5 mos., 23 ds.*

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *retired*  
(b) General nature of industry, business, or establishment in which employed (or employer). *(see dealer)*

9-BIRTHPLACE,

(State or Country), *Balto. Md.*

10-NAME OF FATHER,

*John Gaston*

11-BIRTHPLACE OF FATHER,

(State or Country), *Ireland.*

12-MAIDEN NAME OF MOTHER

*Mary Trainer*

13-BIRTHPLACE OF MOTHER,

(State or Country), *Ireland.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Annie M. Gaston.*

(Address) *2841 W. Laval St.*

15-

Filed *FEB 24 1922*

*NOBERT R. KRAUTER,*

*Burial Permit Clerk.*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*February 22, 1922,*  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, that I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

topsy or inquiry.) and that said deceased came to *his* death on the *day* stated above.

The CAUSE OF DEATH\* was as follows:

*chronic pneumonia.*

(Duration) yrs. mos. *1* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. S. Hennessy, M. D.* (Coroner.)

*Feb. 23, 1922* (Address) *2802 Cambridge St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,

*St. Peter's*

DATE OF BURIAL,

*Feb 25, 1922*

20-UNDERTAKER

*Eastbrook*

ADDRESS

*1038 B. alt St.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61637 HEALTH DEPARTMENT—CITY OF BALTIMORE  
CERTIFICATE OF DEATH. Registered No. C.....  
1-PLACE OF DEATH  
City of BALTIMORE: (No. Cherry Hill, Westport. St. 25 160 Ward)  
2-FULL NAME Goldawonda Schuh.  
(Residence in Baltimore: No. Cherry Hill, Westport. St.; yrs. 1 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.			CORONER'S CERTIFICATE OF DEATH.	
3-SEX. Female.	4-COLOR OR RACE. White.	5-Single, Married, Widowed, or Divorced. Single.	16-DATE OF DEATH, February 21st. 1922. (Month) (Day) (Year)	
6-DATE OF BIRTH, December 31st. 1921. (Month) (Day) (Year)			17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above. The CAUSE OF DEATH* was as follows: Hemorrhagic jaundice. (Duration) yrs. mos. ds.	
7-AGE, 1 mos. 21 ds. If LESS than 1 day, hrs. or min.?			CONTRIBUTORY (Secondary) (Signed) Otto M. Reinhardt M. D. (Coroner.) Feb. 23. 1922. (Address) 1017 E. Charles St.,	
8-OCCUPATION: (a) Trade, profession, or particular kind of work. None. (b) General nature of industry, business, or establishment in which employed (or employer).			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
9-BIRTHPLACE, (State or Country). Baltimore, Md.			18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death. yrs. mos. ds. In the State. yrs. mos. ds. Where was disease contracted, if not at place of death?	
10-NAME OF FATHER, August Schuh.			Former or usual residence.	
11-BIRTHPLACE OF FATHER, (State or Country). Germany.			19-PLACE OF BURIAL OR REMOVAL, St Peters DATE OF BURIAL, Feb 24 1922	
12-MAIDEN NAME OF MOTHER, Florence Buckley.			20-UNDERTAKER, Mr. - Mrs. S. P. Phipps 1831 72 Pratt St. ADDRESS	
13-BIRTHPLACE OF MOTHER, (State or Country). Ohio.				
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Florence Schuh. (mother) (Address) Cherry Hill, Westport.				
15- FEB 24 1922 ROBERT N. KRAUTER, Burial Permit Clerk				

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61638

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 Melbington ST. 20 WARD)

## 2-FULL NAME

(a) RESIDENCE. No. 517 Melbington ST. 20 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Arnold6 DATE OF BIRTH (month, day, and year) Nov. 14 - 18667 AGE Years 55 Months 3 Days 9 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa10 NAME OF FATHER Joseph C. Orlin11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Mary T. Schuch13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt.14 Informant (Address) John Arnold  
517 Melbington Lane15 Filed Feb 24 1922 19Registrar LLY

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 192217 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1921, to Feb 23, 1922that I last saw him alive on Feb 23, 1922.and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH\* was as follows:

Birth of  
girl  
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Had an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Phys. and pathol.  
(Signed) W. A. Hall M. D.19, 19 (Address) 4207 Fred St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park Feb. 25 1922

20 UNDERTAKER ADDRESS

Geo. L. Schuch 2001 E. Pratt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.



Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 61639

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 61639

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *15* WARD)

REGISTERED No. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mary Miller*

(a) RESIDENCE. NO. *1718 Bentalow* ST., WARD. (Usual place of abode)

Length of residence in city or town where death occurred *4* yrs. mos. ds. How long in U. S., if of foreign birth? *4* yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*  
5a If married, widowed, or divorced HUSBAND of *John Miller* (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Jan 20 1847*

7 AGE *75* Years Months Days If LESS than 1 day hrs. or min. *1 3*

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work *nothing* (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Tennessee*

10 NAME OF FATHER *Moses Yant*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Tennessee*

12 MAIDEN NAME OF MOTHER *Ashley*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Tennessee*

14 Informant *Mr. Ella Gilbert* (Address) *118 Bentalow St.*

15 Filed *FEB 24 1922* Registrar *[Signature]*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 23, 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Jan. 30, 1922*, to *Feb. 23, 1922*, that I last saw her alive on *Feb. 22, 1922*, and that death occurred, on the date stated above, at *5:30 a. m.*

The CAUSE OF DEATH\* was as follows: *Pathological fracture shaft right humerus from metastatic carcinoma of right breast* (duration) *2* yrs. mos. ds.

CONTRIBUTORY *General Carcinomatosis* (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *examination* (Signed) *Cyrus J. [Signature]*, M. D.

, 19 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Woodlawn Cemetery* *Feb 25 1922*

20 UNDERTAKER ADDRESS

*Isaac Seyer 1200 N. North St.*

11-801

## 61640

REGISTERED NO.

ST. ... WARD)

(If death occurred in a hospital or institution, give his NAME instead of street and number.)

Martha J. Knoche

ST. . . . . WARD

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 19 66

HEREBY CERTIFY, That I attended deceased from

Feb 21, 1912, to Feb 23, 1912

that I last saw him alive on Feb 22, 1944

and that death occurred, on the date stated above, at 4 PM.

The CAUSE OF DEATH\* was as follows:

At Home 037

La Grippe, with pleurisy  
and Endocarditis

CONTRIBUTORY *Cardiac insufficiency*  
(Secondary) (duration) yrs. mos. *1* ds.

(c) Name of employer

Balto Md  
and Fries

10 NAME OF FATHER

n) *Bath*

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

FEB 24 1922

## Registrar

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? no

**What test confirmed diagnosis?**

(Signed) Rosemary Cross, M. D.

7-~~el~~<sup>22</sup> (Address) 2438 Maryland Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL.

## 20 UNDERTAKER

John Hervey & Co

DATE OF BURIAL

July 26 1927

ADDRESS

2008 Release

D 61641

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *102 N. Seventh Brooklyn Md.*)2-FULL NAME *Minnie T. Bell*(a) RESIDENCE. No. *102 N. Seventh St. Brooklyn Md.*

(Usual place of abode)

Length of residence in city or town where death occurred *62* yrs. — mos. — ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Widowed*

5a If married, widowed, or divorced

HUSBAND of *William Franklin Bell*  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Dec. 11, 1841*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*80 yrs**2**11*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Germany*  
(State or country)10 NAME OF FATHER *Not Known*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Germany*12 MAIDEN NAME OF MOTHER *Not Known*13 BIRTHPLACE OF MOTHER (city or town) *Germany*  
(State or country)

14

Informant *Mr. Edward T. Bell*(Address) *2529 Edmondson Ave*

15

FEB 24 1922

Registrar *EG*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 22* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 20*, 19*22*, to *Feb 22*, 19*22*.that I last saw him alive on *Feb 21*, 19*22*.and that death occurred, on the date stated above, at *6:30* p. m.

The CAUSE OF DEATH\* was as follows:

*Adenitis Sclerosans*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Charles F. Brooks* M. D.*Feb 22*, 19*22* (Address) *2529 Edmondson Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Western Cemetery**Feb 25 1922*

20 UNDERTAKER

ADDRESS

*for foerden's Son 217 S. Pac*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 61642

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *619-4 Lakewood* ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Oscar Littleton McDaniel*(Residence in Baltimore: No. *619-4, Lakewood* St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *M* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *single* (Write the word.)6-DATE OF BIRTH, *Feb. 24, 1922* (Month) (Day) (Year)

7-AGE, If LESS than 1 day, 6 hrs. or min. 1 day, yrs. mos. ds.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *none* (b) General nature of industry, business, or establishment in which employed (or employer). *etc*9-BIRTHPLACE, (State or Country), *Balt.*

PARENTS.	10-NAME OF FATHER, <i>Oscar McDaniel</i>
	11-BIRTHPLACE OF FATHER (State or Country), <i>Balt.</i>
	12-MAIDEN NAME OF MOTHER <i>Mary Samman</i>
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Balt.</i>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Oscar McDaniel*(Address) *619-4 Lakewood*15- *GLY* REGISTRAR. FEB 24 1922

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb 24, 1922* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Feb 24, 1922*, to *Feb 24, 1922*, that I saw him alive on *Feb 24, 1922*, and that death occurred, on the date stated above, at *8 a m.* The CAUSE OF DEATH\* was as follows:*Drumstick poisoning from mother* (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *R. D. Deaver* M. D. *Feb 24, 1922* (Address) *26 W. 5th St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. Is the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*St. Paul Cemetery* *Feb 24, 1922*

20-UNDERTAKER ADDRESS

*Mrs. C. Miller* *2334 E. Pratt*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61643

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1931 E. 32nd* ST.;WARD) *9*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Nancy E. Younkin*(Residence in Baltimore: No. *1931 E. 32nd St.*St.; *10* yrs., mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Female white*

## 4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Widow*

## 6-DATE OF BIRTH,

*July 3, 1884*  
(Month) (Day) (Year)

## 7-AGE,

*67* yrs. mos. ds.

If LESS than 1 day, ... hrs. or ... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE,

(State or Country), *Pa*10-NAME OF FATHER, *Wm Carothers*11-BIRTHPLACE OF FATHER (State or Country), *Pa*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr E. C. Page*(Address) *1931 E. 32nd St*

15-

FEB 24 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb 23, 1922*

(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Feb 23, 1922, to Feb 23, 1922*that I saw him alive on *3 mrs ago 1922*and that death occurred, on the date stated above, at *6 A m.*

The CAUSE OF DEATH\* was as follows:

*Heart Dilatation of heart*

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY *Heart Dilatation*

(Secondary) (Duration) ... yrs. ... mos. ... ds.

(Signed) *John A. Morgan* M. D.*Feb 23, 1922* (Address) *1014 Barry*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the ... yrs. ... mos. ... ds. State ...

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Cornellville Pa*DATE OF BURIAL, *Feb 25, 1922*20-UNDERTAKER *Chas E. Franck* 801 Madison St

## ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. D 61644 Municipal Tuberculosis Hospital ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Washington(a) RESIDENCE. NO. 115 W. Hughes st.ST. 27 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Not recorded6 DATE OF BIRTH (month, day, and year) 18927 AGE Years Months Days If LESS than 1 day, hrs. or min. 30

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Alexandria (State or country) Virginia10 NAME OF FATHER Moses Washington11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country)12 MAIDEN NAME OF MOTHER Lucy Jackson13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)14 Informant Hospital Records (Address) M.T.H.

FEB 24 1922

ROBERT R. KRAUTER,  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1922, to Feb. 19, 1922.

that I last saw her alive on Feb. 18, 1922.

and that death occurred, on the date stated above, at 5.40 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY Spontaneous Pneumothorax (Secondary)

(duration) yrs. 1 mos. 6 ds.

18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum X-ray(Signed) Francis J. Delaney2-19-22 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER Health, Commissioner

ADDRESS

FEB 24 1922

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61645

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

It LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15

Filed

101

ROBERT R. KRAUTER,

Borial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereon and from the evidence obtained by said

And that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

2.23.22, 1922

(Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs.....mos.....ds. In the State....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61646

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

15 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Married

5a If married, widowed, or divorced

(or) WIFE of

Russell Butler

6 DATE OF BIRTH (month, day, and year)

July 4 = 1887

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

34

7

19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Washington D.C.

10 NAME OF FATHER

Matthews Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md

12 MAIDEN NAME OF MOTHER

Sophie Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Washington D.C.

14

Informant (Address)

15

Filed

FEB 24 1922

ROBERT R. KRAUTER

Additional Informant Burial Permit Clerk, Sophie Cook

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 23<sup>rd</sup> 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 22<sup>nd</sup>, 1922, to Feb 23<sup>rd</sup>, 1922,that I last saw him alive on Feb 23<sup>rd</sup>, 1922,

and that death occurred, on the date stated above, at 1:25 a.m.

The CAUSE OF DEATH\* was as follows:

General peritonitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

acute appendicitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9-22-22

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Leo B. B. M. D.

19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt Carmel Cemetery

20 UNDERTAKER

Henry Lutz

N. Broadway

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61647

D 61647

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3330 Beech Ave. ST., 13 WARD)

## 2-FULL NAME

Mary R. Jones

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 3330 Beech Ave. ST., 13 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 3 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Jm. A. Jones

6 DATE OF BIRTH (month, day, and year) Nov. 2 - 1876

7 AGE Years 45 Months 3 Days 20 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Charles C. Rector

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Mary J. Bradford

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Jm. A. Jones (Address) 3330 Beech Ave.

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 1, 1922, to Feb 22, 1922.

that I last saw him alive on Feb 22, 1922.

and that death occurred, on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH\* was as follows:

Secondary Carcinoma of Pelvis  
(Pain hysterectomy Feb 1/19. Pelvic  
tumor will until Sept 24 when  
diagnosed) (duration) yrs. 6 mos. ds.

CONTRIBUTORY In. Pelvic obstruction (Secondary)

(duration) yrs. mos. 25 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No. Date of Feb 1/19

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. B. Norment, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Lynd Ridge

20 UNDERTAKER Horace F. Burgee

ADDRESS 363 Falls Rd.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 24 1922

D 61648

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61648

## CERTIFICATE OF DEATH.

REGISTERED NO. 90

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland Penitentiary* ST. *6* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Emanuel Newman*

## (a) RESIDENCE. NO.

*206 St. Brodum*

ST.

WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Single*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*1899*

## 7 AGE

Years

Months

Days

*23*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*General 040*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Sealer*

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Maryland*

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Russia*

## 12 MAIDEN NAME OF MOTHER

*Anna*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Russia*

## 14

Informant (Address)

*J. J. Mrazek*

## 15

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*February 24 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*February 12, 1922, to February 24, 1922,*that I last saw him alive on *February 24, 1922,*and that death occurred, on the date stated above, at *11:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Edema of Lungs - Cardiac dilatation*(duration) yrs. mos. *3* ds.CONTRIBUTORY *Chronic Endocarditis Toxic*

(Secondary)

(duration) yrs. mos. *13* ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical Examination*(Signed) *William R. Schwartz* M. D.2/24, 1922 (Address) *Maryland Penitentiary.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Mehren Kessing**2/26 1922*

## 20 UNDERTAKER

## ADDRESS

*Jack Lewis 1439 E. Baltimore*

EB 24 1922

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Original  
Physician's  
Statement  
of  
Cause  
of  
Death  
to  
be  
filled  
out  
by  
the  
physician  
attending  
the  
deceased.  
Physicians  
should  
state  
EXACTLY  
the  
cause  
of  
death  
in  
plain  
terms,  
so  
that  
it  
may  
be  
properly  
classified.  
Exact  
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of  
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deceased.  
Physicians  
should  
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EXACTLY  
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properly  
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Exact  
statement  
of  
cause  
of  
death  
to  
be  
filled  
out  
by  
the  
physician  
attending  
the  
deceased.

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61649

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3014 Evergreen Terrace ST., 13 WARD)

2-FULL NAME Annie B. Soloman

(a) RESIDENCE NO. 3014 Evergreen Terrace ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Soloman

6 DATE OF BIRTH (month, day, and year) ----- 1854

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 68

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) London, England

10 NAME OF FATHER David Rapaport

11 BIRTHPLACE OF FATHER (city or town) (State or country) London England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis (Address) 1419 E. Balto St.,

15 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1922

17 I HEREBY CERTIFY, That I attended deceased from January 18, 1922 to Feb 24, 1922 that I last saw him alive on Feb 23, 1922

and that death occurred, on the date stated above, at 2:30 a. m.

The CAUSE OF DEATH\* was as follows:

Myocardial Arteriosclerosis (duration) 2 yrs. mos. ds.

CONTRIBUTORY Central Nervous System (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Thomas, M. D.

Feb 24, 1922 Address 1228 1/2 E. Calver

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61650

## CERTIFICATE OF DEATH.

D 61650

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No.

ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No.

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE 70 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

10 NAME OF FATHER John Conlon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah MacKinnon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant (Address) Mr. Wagner 326 E 21st St.

15 Filed 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2, 22, 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb'y 12, 1922, to Feb'y 22, 1922,

that I last saw him alive on Feb'y 22, 1922,

and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH\* was as follows:

Myocarditis.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) General debility from fall, 1 yr ago (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? No.

(Signed) Hugh Forsythe, M. D.

19 (Address) 424 E. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

EB 24 1922

Burial permit given

Physicians should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



31 D 61651

### CERTIFICATE OF DEATH.

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(b) RESIDENCE. NO

Length of residence in city or town where death occurred

PERSONAL AND STATISTICAL PARTICULARS

5 Single, Married, Widowed,  
or Divorced (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Days

If LESS than  
1 day, ... hrs.  
or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

13 Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23 19 22

17

I HEREBY CERTIFY, That I attended deceased from  
Feb. 20, 1922, to Feb 23, 1922.

that I last saw him alive on Feb 23, 1922.

and that death occurred, on the date stated above, at 1. B. IN

The CAUSE OF DEATH\* was as follows:

**CONTRIBUTORY**  
(Secondary)

(duration) yrs. 70 mos. ds

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy?

**What test confirmed diagnosis?**

(Signed)

2/28/19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

## 20 UNDERTAKER

ADDRESS \_\_\_\_\_

FILED  
FEB 24 1972

Page 1 of 1

D 61652

D 61652

Spec. 6-9-19—H. P. Co.—1000 Bks.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 S. East Ave ST.: 21 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Caroline Siviec(a) RESIDENCE. NO. 1109 S. East Ave ST. 21 WARD.(Usual place of abode) 21 years mos. — ds. How long in U. S., if of foreign birth 21 years mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 31 - 19007 AGE Years 22 Months 1 Days - If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

## 14

Informant (Address)

## 15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 - 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1922, to Feb. 21, 1922.that I last saw her alive on Feb. 20, 1922.and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH\* was as follows:

Myocardial InsufficiencyCONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) yrs. mos. ds. 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical signs(Signed) J. B. Brown M. D.2-23 1922 Address 3037 Odumell St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

St. Stanislaus BeneFeb. 25 1922

## 20 UNDERTAKER

## ADDRESS

Thos. K. Galkowski1000 S. Howard

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 24 1022

D 61653

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61653

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 William ST., 22 WARD)

## 2. FULL NAME

William M. Pearson

## (a) RESIDENCE NO.

813 William ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs.

mos.

ds.

Now long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

M.

## 4 COLOR OR RACE

W.

## 5 Single, Married, Widowed, or Divorced, (write the word)

married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Julia Pearson

## 6 DATE OF BIRTH (month, day, and year)

May 2, 1836

## 7 AGE

83 Years

Months

916 Days

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cooper - Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

New York

## 10 NAME OF FATHER

Geo. A. Pearson

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

England

## 12 MAIDEN NAME OF MOTHER

Jennie Signey

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

England

## 14

Informant (Address)

Julia Pearson  
815 William

## 15

Date

Feb 24 1922

Registrar

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb. 23 1922

## 17

I HEREBY CERTIFY That I attended deceased from

Feb 4th, 1922, to Feb 22nd, 1922.that I last saw him alive on Feb. 22nd, 1922.and that death occurred, on the date stated above, at 7:15 A m.

## THE CAUSE OF DEATH was as follows

Chronic Valvular Disease of Heartdo not know

(duration)

yrs.

mos.

ds.

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

## 18 Where was disease contracted if not at place of death?

do not know

## Did an operation precede death?

no

Date of

## Was there an autopsy?

no

## What test confirmed diagnosis?

Heart Sounds

## (Signed)

H. J. Carrick

M. D.

## Address

412 N. Calhoun

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Baltimore

## DATE OF BURIAL

Feb 25 1922

## 20 UNDERTAKER

Jinkler & Jinkler

## ADDRESS

759 Eager

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61654

CERTIFICATE OF DEATH.

108

61654

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph Hospital* ST.: *6* WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Lillian M. Laird*

(a) RESIDENCE. NO. *2612 E. Fairmount* ST. WARD.

(Usual place of abode) Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F.* 4 COLOR OR RACE *W.* 5 Single, Married, Widowed, or Divorced (write the word) *m.*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Chas. Laird*

6 DATE OF BIRTH (month, day, and year) *1887-Aug. 25*

7 AGE Years *4* Months *5* Days *27* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *H. W.* (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto., City*

10 NAME OF FATHER *Frank Cavanaugh*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto., City*

12 MAIDEN NAME OF MOTHER *Margaret Jorlat*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant *Charles Laird* (Address) *1612 E. Fairmount*

15 *Robert P. Harrison,* Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 22* 19*22*

17 I HEREBY CERTIFY, That I attended deceased from *Feb. 18*, 19*22*, to *Feb. 22*, 19*22*, that I last saw him alive on *Feb. 22*, 19*22*, and that death occurred, on the date stated above, at *10 a. m.* The CAUSE OF DEATH\* was as follows:

*Myocardial Infarction*

(duration) yrs. mos. ds.

CONTRIBUTORY *Septicemia* (Secondary) from infected teeth (duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death?

Did an operation precede death? *transfusion blood* Date of *Feb. 21*

Was there an autopsy? *no*

What test confirmed diagnosis? (Signed) *F. C. Marino*, M. D.

*22, 1922* (Address) *St. Joseph Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Mt. Carmel* DATE OF BURIAL *Feb 25 1922*

20 UNDERTAKER *Richard J. Jickler* ADDRESS *1739 E. Eager*

B 847922



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61655

D 61655

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1912 E. Madison ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

(a) RESIDENCE NO.

1912 E. Madison

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 10 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

MaleWhiteSingle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb 20 1904

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

18102

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

Tailoring

(c) Name of employer

H. H. Tailoring Co.

9 BIRTHPLACE (city or town) (State or country)

Baltimore  
Maryland

10 NAME OF FATHER

Charles A. Subik

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Bohemia

12 MAIDEN NAME OF MOTHER

Emma H. Karfinsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore  
Md.

14

Informant

(Address)

Chas. A. Subik1912 E. Madison St.

15

Robert F. Harrison,

19

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1922

17

I HEREBY CERTIFY, That I attended deceased from

January 1921 to February 20 1922that I last saw him alive on February 20 1922and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH\* was as follows:

Sarcomatous(Abdominal Sarcoma & Sarcoma of Testis)(duration) 1 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayer M. D.1922 (Address) 2005 E. Monument St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy RedeemerFeb 25 1922

20 UNDERTAKER

ADDRESS

Jirkler & JirklerEager

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCASION is very important. See instructions on back of certificates.

FEB 24 1922

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Probably originated in  
fever.*

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.

6-9-19-H. P. Co.-1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61656

## CERTIFICATE OF DEATH.

H 61656

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 S. Ellwood Ave ST.)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry W. Bauersfeld

(a) RESIDENCE. No. 1107 S. Ellwood Ave ST. (Usual place of abode)

WARD. (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S. if of foreign birth? 54 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of Amelia Bauersfeld

6 DATE OF BIRTH (month, day, and year) Jan. 8-1848

7 AGE Years 74 Months 1 Days 14 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) 003

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

10 NAME OF FATHER Aug. Bauersfeld

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country)

14 Informant Amelia Bauersfeld (Address) 1107 S. Ellwood Ave

15 Robert F. Harrison, Registrar

Burial Permit Clerk.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 16 1922 to Feb 22 1922, that I last saw him alive on Feb 22 1922, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH\* was as follows:

Sept. Cerebra, following septic infection of right hand due to abrasion (over) (duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) David W. Jones, M. D.

22/1922 Address) 1011 S. Ellwood Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Carmel Cemetery Feb 25 1922

20 UNDERTAKER ADDRESS

Zinkler + Zinkler 1739 E. Eager

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Slipped and fell  
in yard at home.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61657

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 b. Chester St. 8

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1827 N. Chester St. St.; 42 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

2-SEX Female 3-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single.

6-DATE OF BIRTH April 23, 1853 (Month) (Day) (Year)

7-AGE 68 yrs., 10 mos., 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Home - food

9-BIRTHPLACE (State or Country), Frederick, Md.

10-NAME OF FATHER, Jesse Rine

11-BIRTHPLACE OF FATHER (State or Country), Frederick Co., Md.

12-MAIDEN NAME OF MOTHER, Lucy Ann Grothover

13-BIRTHPLACE OF MOTHER (State or Country), Frederick Co., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George W. Rine (Address) 1924 W. Myrtle St.

15-

Filed..... 241922 Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 24, 1922 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from February 16, 1922, to February 24, 1922, that I saw her alive on February 22, 1922, and that death occurred, on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH was as follows: Acute Bronchitis

(Duration) yrs. mos. ds. 8

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Albert C. Giesecke (Address) 2027 E. Hopkins St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cem. DATE OF BURIAL, Feb. 27, 1922

20-UNDERTAKER, Geo. J. Smith ADDRESS, 11- Fayette

241922 Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

O T

D 61658 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61658

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Probably Duncan's Woods* St. *26* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....*Myra Clare Stone*.....(Residence in Baltimore: No. *3163 Elmora Ave* St.; yrs. *7* mos. *7* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-Single, *Single*  
Married,  
Widowed,  
or Divorced,  
(Write the word.)*Female**White*

6-DATE OF BIRTH,

*June**30**1914*

(Month)

(Day)

(Year)

7-AGE,

*7**7**23*

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

*School-Girl*

(b) General nature of industry, business, or establishment in which employed (or employer).....

*None*

9-BIRTHPLACE,

(State or Country),

*Baltimore Md.*

10-NAME OF FATHER,

*Herbert W. Stone*

11-BIRTHPLACE OF FATHER,

(State or Country),

*Balto. Co. Md.*

12-MAIDEN NAME OF MOTHER,

*Myra Eliza Woodruff*

13-BIRTHPLACE OF MOTHER,

(State or Country),

*New York*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Herbert W. Stone (Father)*(Address) *3163 Elmora Ave*

15-

*Robert P. Harrison,*

Filed.....

192

*Burial Permit Clerk*

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

*20*

(Day)

*22*

(Year)

17-

I HEREBY CERTIFY, That I am of the

remains described above, held an.....  
(Inquest, autopsy or inquiry.)from the evidence obtained by said.....  
(Inquest, au-

topsy or inquiry.) and that said deceased came to..... death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Homicidal by pistol shot*

(Duration)..... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(Signed).....

(Coroner.)

*224 E. 2* (Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs. .... mos. .... ds. In the..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Loudon Park Cemetery**Feb. ...., 1922*

20-UNDERTAKER,

ADDRESS

*STEWART & MOWEN COMPANY**108 W. NORTH AVE*

(WILLIAM F. WOODEN, Successor)

B-8.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificate.

D 61659

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61659

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mount Hope Retmah* ST. *28<sup>th</sup>* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Charles L. Segur*(a) RESIDENCE. NO. *Mount Hope Retmah*ST. *28<sup>th</sup>* WARD. (*Resident*)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *21* yrs. *11* mos. *00* ds. How long in U. S., if of foreign birth? *?* yrs. *?* mos. *?* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced, HUSBAND of (or) WIFE of *William C. Segur*6 DATE OF BIRTH (month, day, and year) *July 23<sup>rd</sup> 1844*7 AGE Years *77* Months *7* Days *1* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*(b) General nature of industry, business, or establishment in which employed (or employer) *None*(c) Name of employer *None*9 BIRTHPLACE (city or town) *unknown* (State or country)10 NAME OF FATHER *Don Alfonso Segur*11 BIRTHPLACE OF FATHER (city or town) *Cortland Co N. York* (State or country)12 MAIDEN NAME OF MOTHER *Minerva Turner*13 BIRTHPLACE OF MOTHER (city or town) *Windsor Vermont* (State or country)14 Informant *Records of Mt Hope Retmah* (Address) *Mt Hope Balto Md.*15 *Robert F. Harrison,*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 24<sup>th</sup> 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 29<sup>th</sup> 1900*, to *Feb 24<sup>th</sup> 1922*, that I last saw him alive on *Feb 22<sup>nd</sup> 1922*, and that death occurred, on the date stated above, at *3.4* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Rheumatism (with Cardiac Complication)*Abt (duration) *6* yrs. *0* mos. *0* ds.CONTRIBUTORY *Chr. Melancholia* (Secondary) *abt* (duration) *22* yrs. *0* mos. *0* ds.18 Where was disease contracted *Baltimore Md* If not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Frank J. Flannery* M. D. *Feb 24<sup>th</sup> 1922* (Address) *Mt Hope Retmah*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Mt Olivet Cemetery* DATE OF BURIAL *Feb 27* 192220 UNDERTAKER *STEWART & MOVEN COMPANY* (WILLIAM F. WOODEN, Successor)

ADDRESS

*108 W. NORTH AVE*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

B 24 1922

Burial Permit Clerk.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61660

D 61660

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *913 N. Rose* ST., *7* WARD)

## 2. FULL NAME

*Genoefor Perini*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

*913 N. Rose* ST.,

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

mos.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Single*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Oct. 9-1920*

## 7 AGE

*1* Years*6* Months*15* Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*

## 10 NAME OF FATHER

*Cesare Perini*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Italy*

## 12 MAIDEN NAME OF MOTHER

*Felomena D. Perini*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Italy*

## 14

Informant (Address)

*Cesare Perini 913 N. Rose St.*

## 15

*Robert H. Harrison,*

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*Feb. 24 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*Feb. 13 1922*, to *Feb. 28 1922*that I last saw her alive on *Feb. 23 1922*and that death occurred, on the date stated above, at *2 P.* m.

The CAUSE OF DEATH\* was as follows:

*Broncho-Pneumonia*(duration) yrs. mos. *6* ds.CONTRIBUTORY (Secondary) *Measles*(duration) yrs. mos. *10* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Sustan A. Put* M. D.2/24, 1922 (Address) *Overlea*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE

*Holy Redeemer Church*

20 UNDERTAKER

*George J. Putt 1735 N. Bond*

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

D 24 1922

Burial Permit Clerk



D 61661

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1222 E. Madison ST. 10 WARD)

## 2-FULL NAME

Marietta La Manna

## (a) RESIDENCE. NO.

1222 E. Madison ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs.

mos.

ds.

How long in U. S. If of foreign birth? 20 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Widow5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

1861

## 7 AGE

60 Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Italy

## 10 NAME OF FATHER

Frances Palmi11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Italy

## 12 MAIDEN NAME OF MOTHER

Maria A. Calabrese13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Italy

## 14

Informant

(Address)

Frank Bellistri  
1222 E. Madison St.

## 15

Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-21-1922

## 17

I HEREBY CERTIFY, That I attended deceased from

July 17, 1922, to Feb 21, 1922,that I last saw him alive on Feb 21, 1922,and that death occurred, on the date stated above, at 8:10 P.M.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration)

yrs.

mos.

6 ds.CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

Physical

(Signed)

W. H. Hornstein, M. D.

2/23, 1922 (Address)

733 Asquith St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Holy Redeemer ChurchFeb 25 1922

## 20 UNDERTAKER

## ADDRESS

George J. Ruth 1735 Haywood St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

B 241922

Burial Permit Clerk

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61662

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 61662

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 1618 Bethel Place)

ST.

WARD)

2-FULL NAME

Hellen Rabst

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

1618 Bethel Place St.; 22 yrs. 9 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE white 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) married

6-DATE OF BIRTH May 1<sup>st</sup> 1899 (Month) (Day) (Year)

7-AGE 22 yrs. 9 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9-BIRTHPLACE (State or country) Baltimore Md

10-NAME OF FATHER Valentin Rabst

11-BIRTHPLACE OF FATHER (State or country) Poland

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or country) Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Valentin Rabst

(Address) 1618 Bethel Place

15- Robert P. Harrison,

191

1922 Burial Permit Clerk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH February 21<sup>st</sup> 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1922, to Feb. 21, 1922, that I saw her alive on Feb. 21, 1922, and that death occurred, on the date stated above, at 10.40 p.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(Duration) 12 mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Samuel Silverstein M. D. Feb. 27<sup>th</sup> 1922 [Address] 22 S. Broadway

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Holy Rosary Feb. 23, 1922

20-ADDRESS

William F. [unclear] Eastern

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61663

## CERTIFICATE OF DEATH.

90 D 61663

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1437 Myrtle W.* ST.: *14* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. *1437 Myrtle W.* ST.: *14* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *83* yrs.

mos.

ds.

How long in U. S., if of foreign birth? *4* yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*Colored*

5 Single, Married, Widowed, or Divorced (write the word)

*Widowed*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*R. Wesley Ray*

6 DATE OF BIRTH (month, day, and year)

*Dec. 13 - 1839*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*83**2**9*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

*At home*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Md.*

10 NAME OF FATHER

*Augustus Marquis*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Md.*

12 MAIDEN NAME OF MOTHER

*Deabelle Parker*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Md.*

14

Informant  
(Address)*George T. Ray (Son)  
1437 Myrtle Ave.*

15

Robert P. Harrison, Registrar

Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb. 22 1922*

17 I HEREBY CERTIFY, That I attended deceased from

*Jan - 22, 1922, to Feb 21, 1922*that I last saw her alive on *Feb 21, 1922*and that death occurred, on the date stated above, at *1 P.* m.

The CAUSE OF DEATH\* was as follows:

*Mitral Insufficiency*CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?*not clear*

Did an operation precede death?

*no*

Was there an autopsy?

*no*

What test confirmed diagnosis?

(Signed)

Feb. 22, 1922

Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Mt. Hope Calvert Co. Md.*

DATE OF BURIAL

*Feb. 25 1922*

20 UNDERTAKER

*Jno. M. Johnson*

ADDRESS

*1234  
Oltung St.*

Physicians should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

B 24 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61664

## CERTIFICATE OF DEATH.

113 D 61664  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 43 Wheeler Ave. ST. 20 WARD)

## 2-FULL NAME

Elwood J. Bailey

## (a) RESIDENCE NO.

43 Wheeler Ave

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

Male white single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

0

0

6

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Balto. Md.

## 10 NAME OF FATHER

Daniel Bailey

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Anconico Co. Md.

## 12 MAIDEN NAME OF MOTHER

Viola Walker

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

## 14

Informant  
(Address)Daniel Bailey  
43 Wheeler Ave

## 15

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1922

17

I HEREBY CERTIFY, That I attended deceased from  
Feb 19 1922, to Feb 24 1922,  
that I last saw him alive on Feb 23 1922,

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH\* was as follows:

Acute Enterocolitis

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

acidosis

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

J. S. Woodruff M. D.  
252 N. Payson St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Hebron Cem. Md

2/25/ 1922

20 UNDERTAKER

ADDRESS

My Cook 502 E. North Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B24 1922

N. Payson St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61665

61665

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No

808 S. Poca

ST.

WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mary E. Ebert

## (a) RESIDENCE. NO.

808 S. Poca

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

F

## 4 COLOR OR RACE

W

## 5 Single, Married, Widowed, or Divorced (write the word)

Widowed

## 5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

Charles Ebert

## 6 DATE OF BIRTH (month, day, and year)

1846 April 10

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

75 1846 April 10

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

City

## 10 NAME OF FATHER

Geo. H. Fonth

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

City

## 12 MAIDEN NAME OF MOTHER

unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant (Address)

Thelma Kohlway 808 S. Poca St.

24 1922

Robert F. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb 24

19 22

## 17

I HEREBY CERTIFY, That I attended deceased from

Mar 31, 1921, to Feb 24, 1922

that I last saw him alive on Feb 22, 1922

and that death occurred, on the date stated above, at 4:50 P. M.

The CAUSE OF DEATH\* was as follows:

Paralysis (Hemiplegia)

(duration) yrs. 2 mos. 24 ds.

## CONTRIBUTORY (Secondary)

Arterio-Sclerosis

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jas. L. Harper, M. D.

2. 1419 1-2 Address 3468 08

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Londow Park

## DATE OF BURIAL

2/27 1922

## 20 UNDERTAKER

William Cook

## ADDRESS

502 E North

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No hemorrhage.  
not apoplectic.*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61666

## CERTIFICATE OF DEATH.

10

D 61666

### PLACE OF DEATH

CITY OF BALTIMORE (No. *2909 Harlem Ave.*, ST. *16* WARD)

2-FULL NAME *Margaret C. Brookhart*

(Residence in Baltimore: No. *2909 Harlem Ave*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH. *July 31*, 1 (Month) (Day) (Year)

7-AGE, *8* yrs., mos., da. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *School Girl* (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. *Balto Md* (State or Country).

10-NAME OF FATHER *George Brookhart*

11-BIRTHPLACE OF FATHER *Balto Md* (State or Country)

12-MAIDEN NAME OF MOTHER *Mary Linsinger*

13-BIRTHPLACE OF MOTHER *Balto Md* (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *George Brookhart*

(Address) *2909 Harlem Ave*

15-

*Robert F. Harrison*

Filed

191

Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

*Feb. 23*, 19*22* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

*quiry* And that said deceased came to *his* death (Inquest, au-

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Diphtheria*

(Duration) yrs. mos. ds.

CONTRIBUTORY *Broncho-Pneumonia* (Secondary)

(Duration) yrs. mos. ds.

(Signed) *R. F. Harrison* M. D. (Coroner.)

*Feb. 24*, 19*22* (Address) *2802 Channing Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. da. State. yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

*Woodlawn* *2/25*, 19*22*

20-UNDERTAKER ADDRESS

*William Cook* *502 E North*

B241922

Funeral Permit Clerk

D 61667

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 61667

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mary Ochinsky

(a) RESIDENCE. NO. 116 3. Greene St

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds.

How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1866

7 AGE

55

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Luthanian

10 NAME OF FATHER

Vincent Ochinsky

11 BIRTHPLACE OF FATHER (city or town)

Unknown

(State or country)

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

Unknown

(State or country)

14

Informant (Address)

Hospital Records,

Municipal Hospital.

15

Filed

Robert F. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23 19 22

17

I HEREBY CERTIFY, That I attended deceased from February 9, 19 22 to February 23, 19 22.

that I last saw him alive on February 23, 19 22.

and that death occurred, on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of liver

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed)

L. H. Dumbauld, M. D.

, 19

(Address)

Municipal Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park

2/27

20 UNDERTAKER

ADDRESS

William Cook

502 E North

B24 1922

Information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 61668

## CERTIFICATE OF DEATH.

31 D 61668

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4514 Weitzel ave ST. 27 WARD)

## REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ann Margaret West(Residence in Baltimore: No. 4514 Weitzel ave St. lf yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)6-DATE OF BIRTH, May 1, 1906 (Month) (Day) (Year)7-AGE, 12 yrs. 9 mos. 22 ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, School girl (b) General nature of industry, business, or establishment in which employed (or employer) 0009-BIRTHPLACE, (State or Country), Baltimore Md.PARENTS. 10-NAME OF FATHER, Harry West 11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md. 12-MAIDEN NAME OF MOTHER, Mary Gutz 13-BIRTHPLACE OF MOTHER (State or Country), West Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida West(Address) 4514 Weitzel ave

15-

Robert P. Harrison

Registrar.

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 23, 1922 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Oct. 6, 1921 to Feb. 23, 1922, that I saw her alive on Feb. 22, 1922, and that death occurred, on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH\* was as follows:

Pulmonary TuberculosisCONTRIBUTORY (Secondary) Exhaustion(Signed) Benj. S. Hayden M. D. Feb. 24, 1922 (Address) 1216 N. Caroline st.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn DATE OF BURIAL, 2/27, 192220-UNDERTAKER, William Cook ADDRESS, 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R 24-1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61669

D 61669

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (Not for use in case of death in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

## (a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## WARD.

(If nonresident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant

(Address)

## 15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb. 18, 1922 to Feb. 24, 1922.

that I last saw him alive on Feb. 24, 1922.

and that death occurred, on the date stated above, at 1:42 P.M.

The CAUSE OF DEATH\* was as follows:

Exhaustion of entire left lower extremity with a General Septicemia

(duration) yrs. mos. 14 ds.

## CONTRIBUTORY (Secondary)

Laceration of left leg

Injured by (duration) Feb. 14, 1922 ds.

18 Where was disease contracted if not at place of death? 1311 Reynolds St.

Did an operation precede death? yes Date of 2-18-22

Was there an autopsy? no Date of 2-23-22

What test confirmed diagnosis? Physical Exam-

(Signed) J. J. Oyster, M. D.

, 19 (Address) University of Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Cedar Hill 2-27 1922

## 20 UNDERTAKER

## ADDRESS

W. Williams Cook 502 E North

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B24 1922

Burial Permit Clerk

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assoc.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Patient stated he  
slipped getting on  
a street car and  
lacerated his leg.  
Struck ship & caused laceration  
O. K. by  
Coroner Gorsch*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61670

CERTIFICATE OF DEATH.

129 D 61670

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 302 Ann ST., V WARD)

2-FULL NAME Sarah N Zimmerman

(a) RESIDENCE NO. 302 Ann ST., WARD

(Usual place of abode) Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Victor Zimmerman

6 DATE OF BIRTH (month, day, and year) Dec 25 1860

7 AGE Years 61 Months 1 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work act

(b) General nature of industry, business, or establishment in which employed (or employer) home

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland (State or country)

10 NAME OF FATHER Zimmerman

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant (Address) Andrew U. Zimmerman 302 Ann St.

15 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1922, to Feb 20, 1922, that I last saw him alive on Feb 20, 1922.

and that death occurred, on the date stated above, at 10:59 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Walden M. D. 2219 22

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

1922 Feb 25 1922

William Cook 302 E North

FR 24 1922



D 61671 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61671

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH 838 1/2 Pl-Park Ave

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 7 WARD)

2-FULL NAME Mary Louise Lamb

(a) RESIDENCE NO. 838 1/2 Pl-Park Ave ST. 7 WARD

(Usual place of abode) Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 13/1872

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Robert P. Harrison,

19

Registrar

Bertal Peratt Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb - 13 - 1922, to Feb - 24 - 1922, that I last saw h. alive on Feb - 22 - 1922, and that death occurred, on the date stated above, at 1230 a. m. The CAUSE OF DEATH\* was as follows:

Gastritis - (chronic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William H. Johnson, M. D.

2/24/1922 (Address) 3016 Guilford Ave.

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 61672

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61672

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1632 Hallis St. ST.: 19 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Williams(a) RESIDENCE. No. 1632 Hallis St. ST.: 19 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of —6 DATE OF BIRTH (month, day, and year) 8/14/967 AGE Years 25 Months 6 Days 10 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work(b) General nature of industry, business, or establishment in which employed (or employer) —(c) Name of employer —9 BIRTHPLACE (city or town) (State or country) Carmar Co. - Maryland10 NAME OF FATHER Wm C Williams

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Carmar Co - Maryland12 MAIDEN NAME OF MOTHER Mary A Hayden

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Carmar Co Maryland14 Informant Mrs M A Dodson(Address) 1632 Hallis St.15 Filed Robert F. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 192217 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1922, to Feb 22, 1922, that I last saw him alive on Jan 21, 1922, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) 3 yrs. — mos. — ds.18 Where was disease contracted if not at place of death? Hallis St.Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? Histology & General(Signed) Dr. Phillips, M. D., 19 (Address) 2300 E. Monument St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Bonnie B. B. B.2/25/1922

20 UNDERTAKER

ADDRESS

John J. F. F. F.1318 Light St.

25 1922 Mortal Permit Clerk.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61673

D 61673

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 N. Dallas ST. 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 102 N. Dallas ST. 30 yrs., mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE.

Colored5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

## 6-DATE OF BIRTH

Feb 5 (Month) (Day) (Year)

## 7-AGE.

55 yrs., 1 mos., 18 da.

If LESS than 1 day, ....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Home mail clerk  
070

## 9-BIRTHPLACE, (State or Country),

Maryland

## 10-NAME OF FATHER,

James Saxton

## 11-BIRTHPLACE OF FATHER (State or Country),

Maryland

## 12-MAIDEN NAME OF MOTHER

Elizabeth Mason

## 13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Delcoursy(Address) 102 N. Dallas

## 15-

Robert T. Harrleeh,191  
Burial Permit

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

Feb 23, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Feb 2, 1922, to Feb 23, 1922that I saw her alive on Feb 22, 1922,and that death occurred, on the date stated above, at 7A m.

The CAUSE OF DEATH\* was as follows:

Ulceration of Mouth  
& Throat

(Duration) .... yrs. .... mos. .... da.

## CONTRIBUTORY (Secondary)

Salivary Mercury poisoning  
from Colomel application(Signed) R. D. Harrleeh, M.D.Feb 23, 1922 (Address) 102 N. Dallas

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... da. In the State .... yrs. .... mos. .... da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Int. Burial Co.

## DATE OF BURIAL,

Feb 25, 1922

## 20-UNDERTAKER

Mrs Robert A. Harrleeh

## ADDRESS

725

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FEB 25 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61674

## CERTIFICATE OF DEATH.

90 D 61674

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *147 N. Henrietta* ST. *23rd* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *William Clarence Robinson*(a) RESIDENCE. No. *147 N. Henrietta* ST. *23rd* WARD.

(Usual place of abode)

(if nonresident give city or town and State)

Length of residence in city or town where death occurred *27* yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

*Mrs. Rosie Ella Robinson*6 DATE OF BIRTH (month, day, and year) *Jan. 26-1864*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*58* *7* *0* *27*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer 140*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Chemical Plant*

(c) Name of employer

*Prudential Oil Co.*

9 BIRTHPLACE (city or town) (State or country)

*King & Queen County Va.*10 NAME OF FATHER *Wm Robinson*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*King & Queen County Va.*12 MAIDEN NAME OF MOTHER *Agnes Brown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Va.*

14

Informant (Address)

*Mrs. Rosie Robinson 147 N. Henrietta St.*

15

*Robert E. Harrison,*

Registrar

Burial Permit *142*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 22nd* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan. 18th*, 19*22*, to *Feb. 22nd*, 19*22*.that I last saw him alive on *Feb. 18th*, 19*22*.and that death occurred, on the date stated above, at *6:45 P. M.*

The CAUSE OF DEATH\* was as follows:

*Acute Endocarditis (Exacerbation)*CONTRIBUTORY (Secondary) *Chronic Endocarditis* (duration) yrs. mos. ds. *Indefinite*

18 Where was disease contracted if not at place of death?

*Baltimore, Md.*Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Physical Exam.*(Signed) *James Edwin Bell, M.D.*, 19 (Address) *1224 N. Gilman St.*

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mt. Auburn Cem**2-25-22*

20 UNDERTAKER

ADDRESS *142**John H. Treadin**U.S. Steel &*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

B25 1922



D 61675

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61675

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 565 Presstman ST., 14 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Rachel Nichols

## (a) RESIDENCE No.

565 Presstman ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 1/2 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced

(or) WIFE of

Thomas Nichols

## 6 DATE OF BIRTH (month, day, and year)

Dec 25, 1853

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.68117

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Cambridge Md.

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

## 14

Informant  
(Address)Thomas Nichols  
565 Presstman St

## 15

Filed

Robert P. HarrisonBurial Permit Clerk

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 19 22

17

I HEREBY CERTIFY, That I attended deceased from Feb 21, 19 22, to Feb 24, 19 22.that I last saw her alive on Feb 23, 19 22.and that death occurred, on the date stated above, at 6:15 A. m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis(duration) 1 yrs. 0 mos. 0 ds.

## CONTRIBUTORY (Secondary)

(duration) 0 yrs. 0 mos. 0 ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Frey, M. D.Feb 24, 1922 (Address) 1928 Penna Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

## 20 UNDERTAKER

Cambridge Ind  
George H. Holland

## DATE OF BURIAL

Feb 27 19 22

## ADDRESS

1681 Harwin  
Hill Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

EB 25 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61676

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 Druid Hill Ave. ST. 14 WARD)

2. FULL NAME Daniel Edward Brown

(a) RESIDENCE No. 1715 Druid Hill Ave. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 1/2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Georgianna Brown

6 DATE OF BIRTH (month, day, and year) Dec 15, 1859

7 AGE Years 62 Months 2 Days 8 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

10 NAME OF FATHER Daniel Edward Brown

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Henrietta Wallace

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Georgianna Brown (Address) 1715 Druid Hill Ave

15 Robert P. Harrison Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23, 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1922, to Feb. 23, 1922, that I last saw him alive on Feb. 21, 1922, and that death occurred, on the date stated above, at 10:30 P.M. The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTOR (Secondary) (duration) yrs. mos. ds. 4

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Biopsy (Signed) A. Lee Collins M. D.

424, 1922 (Address) 924 Madison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOV. Mt Auburn Cmty Feb 27, 1922

20 UNDERTAKER

ADDRESS

George H. Holland 1631 Spring Hill Ave

D 61677

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61677

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4708 Garrison Avenue ST. 15 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Alexander Thompson

(a) RESIDENCE. NO. 4708 Garrison Ave. ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 10 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Annie R. Hughes

6 DATE OF BIRTH (month, day, and year) April 9, 1849

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

72 10 14

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Lithographer

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER Arthur Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER Anne Elizabeth Biggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Arthur Thompson (Address) Candler Building

15 Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 18 1922, to Feb. 23 1922,

that I last saw him alive on Feb. 22 1922,

and that death occurred, on the date stated above, at 8:20 A.M.

The CAUSE OF DEATH\* was as follows:

Complication of Arteriosclerosis  
Nephritis with uraemia and  
cerebral edema (no paralysis)

(duration) ? yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary)

Resp. Failure

(duration) — yrs. — mos. — ds.

18 Where was disease contracted — if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Consult. Dr. Bayley &amp; Dr. Wilford.

(Signed) Stanley Cole, M. D.

19 (Address) 2202 E. Morris Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Green Mount Cemetery

2/25, 1922

20 UNDERTAKER

ADDRESS

Henry W. Mears &amp; Son 805 N. Calvert

Burial Permit Clerk.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR- TION is very important. See instructions on back of certificates.

EB 25 1922

Spec.—1-10-21—M&T—1500 Bks.  
D 61678  
HEALTH DEPARTMENT—CITY OF BALTIMORE  
CERTIFICATE OF DEATH.  
1-PLACE OF DEATH  
CITY OF BALTIMORE: (No. 1027 Federal Ave. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
2-FULL NAME Ed. Diggs  
(a) RESIDENCE NO. 1027 Federal Ave. ST. WARD  
(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.  
PERSONAL AND STATISTICAL PARTICULARS  
3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, Divorced, write the word Single  
5a If married, widowed, or divorced HUSBAND of (or) WIFE of  
6 DATE OF BIRTH (month, day, and year) 4/20/22  
7 AGE Years Months Days If LESS than 1 day, hrs. or min. 1  
8 OCCUPATION OF DECEASED  
(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer  
9 BIRTHPLACE (city or town) (State or country) 1027 Federal Ave. D.C.  
10 NAME OF FATHER Ed. Diggs  
11 BIRTHPLACE OF FATHER (city or town) (State or country)  
12 MAIDEN NAME OF MOTHER Martha Diggs  
13 BIRTHPLACE OF MOTHER (city or town) (State or country) D.C.  
14 Informant (Address) Robert F. Harrison  
15 1922  
16 DATE OF DEATH (month, day, and year) 4/21/22  
17 I HEREBY CERTIFY, That I attended deceased from 4/20/22 to 4/21/22, that I last saw him alive on 4/21/22, and that death occurred, on the date stated above, at 7:00 p.m. The CAUSE OF DEATH\* was as follows:  
Gastrointestinal hemorrhage due to ulcer  
Pneumonia (duration) yrs. mos. ds. 1  
CONTRIBUTORY (Secondary) Peritonitis at birth (duration) yrs. mos. ds.  
18 Where was disease contracted if not at place of death?  
Did an operation precede death? no Date of  
Was there an autopsy? no  
What test confirmed diagnosis?  
(Signed) A. R. Ellis, M. D.  
19 (Address) 927 Madison Ave.  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)  
19 PLACE OF BURIAL, CREMATION OR REMOVAL John Hopkins Lab.  
20 UNDERTAKER  
DATE OF BURIAL 19  
ADDRESS  
EB 25 1922  
Bureau of Vital Statistics  
Registrar



D 61679 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61679

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 445-W. 24

2-FULL NAME

(Residence in Baltimore: No. 445 W. 24 st

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Mr.* 4-COLOR OR RACE *W.* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH *Feb 24, 1922*  
(Month) (Day) (Year)

7-AGE, *4* yrs., *7* mos., *7* ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work... *Baby*  
(b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE, (State or Country) *Balt Md*

10-NAME OF FATHER, *E. Z. Schult*

11-BIRTHPLACE OF FATHER (State or Country) *Balt Md*

12-MAIDEN NAME OF MOTHER *Elsie Schmitt*

13-BIRTHPLACE OF MOTHER (State or Country) *Balt Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *E. Z. Schult*

(Address) *445-24 st*

15-

*Robert F. Harrison*

191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *Feb 24, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, THAT I took charge of the remains described above, held an inquest, and that the evidence obtained by said inquest and from the evidence obtained by said inquest and that said deceased came to death on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
*Heart disease*

CONTRIBUTORY (Secondary) (Duration) .... yrs. .... mos. .... ds.

(Signed) *Robert F. Harrison* M. D. (Coroner.)  
(Address) *7132 Roland*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death .... yrs. .... mos. .... ds. State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence. ....

19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer Ch.*

DATE OF BURIAL, *Feb 25, 1922*

20-UNDERTAKER *Lilly & Zeile*

ADDRESS *403 S. Mifflin*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

B 25 1922

## *Congenital malformation*

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*,

*peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septichæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

*Abortion*, *Hæmorrhage*, *Meningitis*, *Phlebitis*,  
*Cellulitis*, *Gangrene*, *Miscarriage*, *Pyæmia*,  
*Childbirth*, *Gastritis*, *Necrosis*, *Septicæmia*,  
*Convulsions*, *Erysipelas*, *Peritonitis*, *Tetanus*.

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved): *Snicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61680

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1212 Warner St. St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....Joseph P. Cunningham.

(Residence in Baltimore: No. 1212 Warner St. St.; yrs. 3 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 4-COLOR OR RACE, 5-Single, Married, Widowed or Divorced. (Write the word.)  
Male, White, Single

6-DATE OF BIRTH, November 7th, 1921, 1.....  
(Month) (Day) (Year)

7-AGE, If LESS than 1 day, .....hrs. or .....min.?  
.....yrs. 3 mos. 16 ds.

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work.....None  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Peter J. Cunningham.

11-BIRTHPLACE OF FATHER, (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Barbara Zant.

13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barbara Cunningham. (mother)

(Address) 1212 Warner St.

15- Robert P. Harrison, Registrar.

Filed 1922

B25 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 23rd, 1922, 192.....  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to a death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia.

(Duration) .....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Feb. 24, 1922. (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

New Cathedral Am. Feb. 25, 1922

20-UNDERTAKER, ADDRESS

James Lignan & Son 1000 E. Park St.

IMORE 101-021 61681

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (NO. 100-103,450 ST. 103 WARD 10)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 916 S (Yan) St St.; 2 yrs.,    mos.,    ds.)

### MEDICAL CERTIFICATE OF DEATH.

3-SEX.

4-COLOR OR RACE.

5-SINGLE,  
MARRIED, S  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

C-DATE OF BIRTH.

....., 1706  
(Month) (Day) (Year)

7-AGE.

16 yrs. .... mos. .... da. .... hrs. or .... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....

**D-BIRTHPLACE,**  
(State or Country).

10-NAME OF  
FATHER,

11-BIRTHPLACE  
OF FATHER  
(State or Country).

12-MAIDEN NAME  
OF MOTHER

**13-BIRTHPLACE  
OF MOTHER  
(State or Country)**

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Robert P. Harrison,

Fused..... 191.....

R25 1922 Serial Permit Clerk Registrar.

16-DATE OF DEATH, *Feb.* 23, 1922.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from  
Jan - 22, 1922, to Feb 23 1922  
that I saw him alive on Feb 23 1922  
and that death occurred, on the date stated above, at m

The CAUSE OF DEATH\* was as follows:

..... (Duration).....yrs.....mos. 21.da

CONTRIBUTORY.....*Indemnity*.....  
(Secondary)

..... (Duration) ..... yrs. .... mos. .... 7. da

(Signed) Newton J. Carr M. D.

2/23, 1912 (Address) Franklin D. Roosevelt

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death \_\_\_\_\_ yrs. 1 mos. \_\_\_\_\_ ds. In the State 16 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
if not at place of death? *At home.*

Former or usual residence 916 J Pacu street

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.

London Park Cemetery. Feb. 25, 192.

<b>20-UNDERTAKER</b>	<b>ADDRESS</b>
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James Gignard & Son	1000 S. Paces
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D 61682 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61682

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *112* St. *Ward*)

2-FULL NAME...

(Residence in Baltimore: No. *2716* St. *Ward* yrs. *11* mos. *29* ds.)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, *Married*

6-DATE OF BIRTH, *Feb. 24, 1845*  
(Month) (Day) (Year)

7-AGE, *47* yrs. *11* mos. *29* ds. If LESS than 1 day, *hrs. or min.?*

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *Chaffeur*  
(b) General nature of industry, business, or establishment in which employed (or employer), *at home*

9-BIRTHPLACE, (State or Country), *Balto*

10-NAME OF FATHER, *John Hubbard*  
11-BIRTHPLACE OF FATHER, (State or Country), *Balto*  
12-MAIDEN NAME OF MOTHER, *Jennie Brown*  
13-BIRTHPLACE OF MOTHER, (State or Country), *Balto Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) *Blanche Hubbard*  
(Address) *2716 Wilkes ave.*

15- *Robert P. Harrison,*  
192 *Serial Permit Clerk, Registrar.*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb. 23-22*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Inquiry* (Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH was as follows: *Ac. Gastritis*

CONTRIBUTOR (Secondary) *Lardner Park*  
(Duration) *2 hrs.*  
(Signed) *G. E. Blodgett* M. D.  
(Address) *1428 S. Chase*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).  
At place of death, *11* yrs. *11* mos. *29* ds. In the State, *11* yrs. *11* mos. *29* ds.  
Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Londan Park* DATE OF BURIAL, *Feb 27, 1922*

20-UNDERTAKER, *Mr. J. E. Lander* ADDRESS *1428 S. Chase*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

B 25 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61683

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2302 Harlem Ave ST., 16 WARD)

## 2-FULL NAME

Mary Katherine Dorsey

## (a) RESIDENCE NO.

2302 Harlem Ave

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

49 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

March 1 1836

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

86825

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

At home

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Simpsonville, Howard Co. Md.

## 10 NAME OF FATHER

Amos Dorsey

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Simpsonville, Howard Co.

## 12 MAIDEN NAME OF MOTHER

Erline?

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Kentucky?

## 14

Informant (Address)

Mrs C. H. Galtner 2302 Harlem Ave

## 15

Filed

Robert P. Harrison,

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 20 1922 to Feb 24 1922that I last saw her alive on Feb 24 1922and that death occurred, on the date stated above, at 6.03 p. m.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia, with chief focus in lower lobe of left lung(duration) yrs. mos. 5 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? none

(Signed)

Lawrence B. Galtner M. D.

, 19

(Address)

1111 W. Linnvale St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MORAL

Elizabethtown

## 20 UNDERTAKER

William Cook

## DATE OF BURIAL

2/26 1922

## ADDRESS

502 E. North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

EB 25 1922 Burial Permit Clerk.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61684

90 D 61684

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 N. Anity ST. 18 WARD)

REGISTERED NO. C

2-FULL NAME Mary Alice Hawkins

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 208 N. Anity St. 35 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female4-COLOR OR RACE, Caucasian5-SINGLE, Widowed  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)6-DATE OF BIRTH, Dec 22, 1868

(Month)

(Day)

(Year)

7-AGE, 53 yrs., 2 mos., ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Domestic(b) General nature of industry, business, or establishment in which employed (or employer), 0709-BIRTHPLACE, (State or Country), Richmond Co. Va10-NAME OF FATHER, Henry Green11-BIRTHPLACE OF FATHER (State or Country), Richmond Co. Va12-MAIDEN NAME OF MOTHER, Lucy Mc Nam13-BIRTHPLACE OF MOTHER (State or Country), Richmond Co. Va

14-THIS ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. P. Hughes(Address) 637 N. Mosher St

15-

Robert P. Harrison,

Registrar.

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 21, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 1921, to Feb 21 1922, that I saw her alive on Feb 20 1922, and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH\* was as follows:

Mitral Insufficiency(Duration) 1 yrs., 1 mos., 14 ds.CONTRIBUTORY (Secondary) Exhaustion(Duration) 1 yrs., 1 mos., 14 ds.(Signed) H. P. Hughes M. D.  
Feb 21 1922 (Address) 637 Mosher St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, CemeteryDATE OF BURIAL, Feb 21, 192220-UNDERTAKER, Samuel HensleyADDRESS 578

EB 25-1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61685

D 61685

## CERTIFICATE OF DEATH.

31

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2713 E La Fayette ST., 8 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Maria Dorothy Schaefer(a) RESIDENCE NO. 2713 E La Fayette ST., 8 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs.  mos.  ds. How long in U. S., if of foreign birth?  yrs.  mos.  ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Schaefer6 DATE OF BIRTH (month, day, and year) Oct 15 - 18967 AGE Years 26 Months 4 Days 8 If LESS than 1 day,  hrs. or  min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) MD10 NAME OF FATHER John Schaefer11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) MD12 MAIDEN NAME OF MOTHER Mary France13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) MD

14

Informant John Schaefer (Address) 2713 E La Fayette Ave

15

Robert P. Harrison,

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 192217 I HEREBY CERTIFY, That I attended deceased from Oct 28 1921 to July 23 1922, that I last saw her alive on July 22 1922 and that death occurred, on the date stated above, at 8:28 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis(duration) yrs. 4 mos.  ds.CONTRIBUTORY (Secondary) Exhaustion(duration) yrs.  mos.  ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter R. White, M. D.19 (Address) 2800 N. Paul St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mount Carmel CemJuly 25 1922

20 UNDERTAKER

ADDRESS

J. Hervey & Co2008 Alameda

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B25 1922

Special Permit Clerk.



Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61686

HEALTH DEPARTMENT—CITY OF BALTIMORE

168 D 61686

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Back of Mt. Holly St.*)

2-FULL NAME

(Residence in Baltimore: No. *2105 Gough St.*)

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: *4* yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*male*

4-COLOR OR RACE,

*white*

5-SINGLE, *married*,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

*Unknown*, 186*8*  
(Month) (Day) (Year)

7-AGE,

*55* yrs., mos. da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Day Laborer*  
(b) General nature of industry, business, or establishment in which employed (or employer). *040*

9-BIRTHPLACE,  
(State or Country),

*Russia Poland*

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Francis Skraczewski*

(Address) *2105 Gough St.*

15-

*Robert P. Harrison,*

101

Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Feb. 21*, 19*22*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest*  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*  
(Inquest, au-

*opsy* and that said deceased came to *his* death  
(Inquest, au-  
opsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Suicide by hanging*  
*Duration* (Duration) yrs. mos. da.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. da.

(Signed) *J. T. Hennessy*, M. D.

*Feb. 24*, 19*22* (Address) *2802 Edmondson Ave.*  
(Coroner.)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. da. State... yrs. mos. da.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,

*St. Stanislaw.*

DATE OF BURIAL,

*Feb. 28*, 19*22*.

20-UNDERTAKER

*M. F. Sadowski*

ADDRESS

*705 S. Ann St.*

825 1922

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT--CITY OF BALTIMORE

D 61687

## CERTIFICATE OF DEATH

REGISTERED NO. C

61687

1-PLACE OF DEATH

CITY OF BALTIMORE: (No

2-FULL NAME

(Residence in Baltimore: No

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than  
1 day, 10 hrs.,  
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE  
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER  
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Robert P. Harrison,

191

REGISTRAR

Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Feb. 24, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from  
191, to, 191,

that I saw h..... alive on 191,  
and that death occurred, on the date stated above, at about 8 p.m.

The CAUSE OF DEATH\* was as follows:

Contributory  
(SECONDARY)

(Signed)

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state statement of OCCUPATION. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

20.61688 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.61688

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Riley(a) RESIDENCE. NO. 5 E. Mulberry St.ST. 4 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 69 -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Norfolk,(State or country) Virginia10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Norfolk,(State or country) Virginia12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Norfolk,(State or country) Virginia14 Informant Hospital Records,(Address) Municipal Hospital15 24 1922 Robert P. Garrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22 1922

17 I HEREBY CERTIFY, That I attended deceased from February 18, 19 22, to February 22, 19 22 that I last saw him alive on February 22, 19 22, and that death occurred, on the date stated above, at 7:15 P. M.

The CAUSE OF DEATH\* was as follows:

Coronary of Colon

CONTRIBUTORY (Secondary) Pulmonary embolus (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Clayton M. Reed, M. D.2/23/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF 1922

HOPKINS HOSPITAL

Commissioner Health,

Per. Wm. E. Wood

FEB 25 1922

WRITE PLAINLY, WITH CAPITALS. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61689 HEALTH DEPARTMENT—CITY OF BALTIMORE 180- D 61689  
CERTIFICATE OF DEATH.

PLACE OF DEATH  
CITY OF BALTIMORE (No. 1019 N. Vinces St. 16 WARD)  
FULL NAME Joseph Beach  
(Residence in Baltimore: No. 1019 N. Vinces St. 19 mos. da.)  
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male 4-COLOR OR RACE, colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)  
6-DATE OF BIRTH, July 19, 1920 (Month) (Day) (Year)  
7-AGE, 1 yrs. 7 mos. 4 ds. If LESS than 1 day, ....hrs. or....min.  
8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, none  
(b) General nature of industry, business, or establishment in which employed (or employer), (Infant)  
9-BIRTHPLACE, (State or Country), Balto., Md.  
10-NAME OF FATHER, Mr. Beach  
11-BIRTHPLACE OF FATHER (State or Country), N. Carolina  
12-MAIDEN NAME OF MOTHER, Martha Fox  
13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Beach  
(Address) 1019 N. Vinces St.

15- Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH, Feb. 23, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Pneumonia  
(Duration) .... yrs. .... mos. 3 ds.

CONTRIBUTORY (Secondary) ...  
(Duration) .... yrs. .... mos. .... ds.

(Signed) J. D. Harrison, M. D. (Coroner.)  
Feb. 25, 1922 (Address) 2802 E. ...

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn DATE OF BURIAL, 2/25/22, 10...

20-UNDERTAKER, Sam. N. Chase ADDRESS, 1400 ...



Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61690

## CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *St. J. Hospital*)

2-FULL NAME

(Residence in Baltimore: No. *1812 n Broadway*)

WARD) *8*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

40 St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, ....hrs. or ....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison

Burial Permit Clerk.

Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said..... (Inquest, au-

topsy or inquiry.) find that said deceased came to..... death of the day stated above.

THE CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

(Coroner)

2-24, 1012 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

John Ouiteluc 1201 N. Fayette St.

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61691

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61691

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

2-FULL NAME

(Residence in Baltimore: No. \_\_\_\_\_ St. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.)

Registered No. C \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-Single  
Married  
Widowed  
or Divorced  
(Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day

8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,  
(State or Country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER,  
(State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER,  
(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

192

Robert P. Harrison,

Registrar.

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH

17-

I HEREBY CERTIFY that I took \_\_\_\_\_ remains described above, held \_\_\_\_\_ (quest, autopsy or inquiry.)

hereon and from the evidence obtained by \_\_\_\_\_ (quest, autopsy or inquiry.) and that said deceased came to \_\_\_\_\_ death on the day stated above.

The CAUSE OF DEATH was as follows:

CONTRIBUTORS  
(Secondary)

(Signed)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61692

D 61692

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No.

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Robert F. Harrison, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Feb 23, 1922, to Feb 23, 1922,

that I last saw her alive on Feb 23, 1922,

and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mrs. J. L. Lister, M. D.

(Address) 1038 Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61693

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 N. London Ave ST. 20 WARD)

2-FULL NAME David Kane

(a) RESIDENCE NO. 520 N. London Ave ST. 20 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 24. 22

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 4

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Joseph F. Kane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Ruth A. Farmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Joseph F. Kane. (Address)

15 Robert P. Harrison Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 19 22

17

I HEREBY CERTIFY, That I attended deceased from Feb. 21, 19 22 to Feb 24, 19 22.

that I last saw him alive on Feb 23, 19 22.

and that death occurred, on the date stated above, at 20 m.

The CAUSE OF DEATH\* was as follows:

Premature delivery at 4 1/2 months  
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harold W. Jones M. D.

224 22 (Address) Danville

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Balto. Cemetery

2/25/19 22

20 UNDERTAKER

Wm. E. East  
502 E. North Ave

ADDRESS

825 1922

Serial Permit Clerk.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61694

D 61694

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 Rueckert Ave. ST. 77 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine E. Weller.(a) RESIDENCE. NO. 7 Rueckert ST. 77 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofHusband of late Melchor Weller.6 DATE OF BIRTH (month, day, and year) Dec 10 18447 AGE Years 77 Months 2 Days 14 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Seeger Germany10 NAME OF FATHER Casper Gung.11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.12 MAIDEN NAME OF MOTHER Not known13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.14 Informant (Address) Mr. Gung.  
7 Rueckert.15 Filed Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 192217 I HEREBY CERTIFY, That I attended deceased from Feb 13 1922, to Feb 24 1922.that I last saw her alive on Feb 24 1922.and that death occurred, on the date stated above, at 10:45 p. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia.(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

if not at place of death? ✓Did an operation precede death? no Date of ✓Was there an autopsy? noWhat test confirmed diagnosis? urine(Signed) Immanuel Com., M. D., 19 (Address) 125 S. 17th

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Immanuel Com.Feb 27 19

20 UNDERTAKER

Reumann.

ADDRESS

321 N. Broadway

B25 1922

Burial Permit Clerk.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of UPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.  
D 61695  
HEALTH DEPARTMENT—CITY OF BALTIMORE 26919 D  
CERTIFICATE OF DEATH. X 90  
1-PLACE OF DEATH  
CITY OF BALTIMORE: (No. 1104 N Eutaw ST., 11 WARD)  
2-FULL NAME Pearl Ethel Houck  
(a) RESIDENCE No. 1104 N Eutaw ST., WARD New Port Del  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.  
PERSONAL AND STATISTICAL PARTICULARS  
3 SEX F. 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married  
5a If married, widowed, or divorced HUSBAND of John L Houck (or) WIFE of  
6 DATE OF BIRTH (month, day, and year) 36  
7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
8 OCCUPATION OF DECEASED  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer) 037  
(c) Name of employer  
9 BIRTHPLACE (city or town) Ind. (State or country)  
10 NAME OF FATHER W B H Wilson  
11 BIRTHPLACE OF FATHER (city or town) Kansas (State or country)  
12 MAIDEN NAME OF MOTHER Hummuth  
13 BIRTHPLACE OF MOTHER (city or town) Ohio (State or country)  
14 Informant John L Houck (Address) 1104 N Eutaw St.  
B25 1922 19 Registrar  
Pieral Permit Clerk

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE 26919 D

D 61695

## CERTIFICATE OF DEATH. X 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 N Eutaw ST., 11 WARD)

### 2-FULL NAME

Pearl Ethel Houck

### (a) RESIDENCE No.

1104 N Eutaw ST.,

WARD

New Port Del

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 9 mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

John L Houck

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

36

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ind.

10 NAME OF FATHER

W B H Wilson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Kansas

12 MAIDEN NAME OF MOTHER

Hummuth

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ohio

14

Informant (Address)

John L Houck 1104 N Eutaw St.

B25 1922

19

Pieral Permit Clerk

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 1922

17 I HEREBY CERTIFY, That I attended deceased from November 19 21 to Feb 24 1922.

that I last saw her alive on Feb 24th 1922.

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH\* was as follows:

Myocarditis, Chronic.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds. Valvular disease of heart

(duration) ? yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? do not know.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

George J. Hall, M. D. 712 Park Ave Bldg

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Port Del

20 UNDERTAKER

H. M. Rouillon

DATE OF BURIAL

Feb 28 1922

ADDRESS

2235 M with are

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

61696 61696

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 Archer ST. 7-1 WARD)

2-FULL NAME

Rebecca Quill

(a) RESIDENCE. No. 604 Archer ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

col

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Widowed

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

61

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Calvert County Md

10 NAME OF FATHER

Isaac Barney

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Calvert County Md

12 MAIDEN NAME OF MOTHER

Rebecca Cornbury

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Calvert County Md

14

Informant (Address)

Daniel E. Quill 628 Archer St

15

Filed FEB 26 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-23-1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 19, 1922, to Feb 23, 1922

that I last saw him alive on Feb 23, 1922

and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen J. Dean, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Ant Antenna Cemetery

2/26 1922

20 UNDERTAKER

ADDRESS

Mrs. Geo. H. Wolfe 406 W. Conway St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 61697

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61697

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital

ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Boswell

(a) RESIDENCE. NO. Ashland Ave ST. 744 W. Mulberry WARD. 17  
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. 744 W. Mulberry mos. 744 W. Mulberry ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE Years 55 Months -- Days -- If LESS than 1 day, -- hrs. -- or -- min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Montgomery, Alabama,  
(State or country)

10 NAME OF FATHER John Boswell

11 BIRTHPLACE OF FATHER (city or town) Alabama  
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Alabama  
(State or country)

14 Informant Hospital Records,  
(Address) Municipal Hospital.

15 Filed Feb 26 1922 Registrar Robert L. Hunter  
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23 19 22

17 I HEREBY CERTIFY, That I attended deceased from February 18, 1922, to February 23, 1922,  
that I last saw him alive on February 22, 1922,  
and that death occurred, on the date stated above, at 12:15 A.M.  
The CAUSE OF DEATH\* was as follows:

Cerebral Remountage  
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clyde W. Meil M. D.  
(Signed)

2/23/22 Address Municipal Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Andrew's

Feb 27 1922

20 UNDERTAKER

ADDRESS

Daniel Carlton

Be en



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61698

## CERTIFICATE OF DEATH.

REGISTERED No. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 amropeis ave ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME bergonna Lyles(Residence in Baltimore: No. 704 amropeis ave Mt Vernon St.; 50 yrs., 0 mos. 0 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX 2 4-COLOR OR RACE col 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow6-DATE OF BIRTH, unknown 1957  
(Month) (Day) (Year)7-AGE, 71 yrs. 0 mos. 0 ds. If LESS than 1 day, ....hrs. or....min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer) 0009-BIRTHPLACE, (State or Country), ind10-NAME OF FATHER, Jayelle Womble11-BIRTHPLACE OF FATHER (State or Country), ind12-MAIDEN NAME OF MOTHER unknown13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. S. Bright(Address) Mt Vernon

15-

FEB 26 1922 ROBERT A. KRAUTER, Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2-24- 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from 2-13 1922, to 2-20 1922, that I saw her alive on 2-20- 1922, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:

Paralysis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pericardial infarction

(Duration) ....yrs. ....mos. ....ds.

(Signed) W. S. Bright M. D.2-25- 1922 (Address) 1400 E. Pratt

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt VernonDATE OF BURIAL, FEB 26, 192220-UNDERTAKER Daniel CarterADDRESS 916

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE, 002

D 61699

## CERTIFICATE OF DEATH.

D 61699

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE, (No. 1021 Argyle Ave. 17)

ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1021 Argyle Ave. St. 17 3 mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

Nov 14 ~, 1921  
(Month) (Day) (Year)

7-AGE,

3 yrs. 3 mos. da.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MARDEN NAME OR MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Kent

(Address) 1021 Argyle Ave.

15-FEB 26 1922

ROBERT R. KRAUTER,

Filed

191

Burial Permit

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Feb 22 1922, to Feb 24 1922

that I saw her alive on Feb 24 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) John D. Thompson, M. D.

2-25-1922 (Address) 704 W. Argyle Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Auburn Bur

Mar 26, 1922

20-UNDERTAKER

ADDRESS 916

Daniel Easton

Sta me

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61700

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61700

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *736 Paris*)

## 2-FULL NAME

(Residence in Baltimore: No. *736 Paris St*)

## REGISTERED NO. C

ST. *17* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: *2* yrs. *2* mos. *6* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Female*

## 4-COLOR

*Caf*

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

*Single*

## 6-DATE OF BIRTH

*March 2, 1919*  
(Month) (Day) (Year)

## 7-AGE,

*2 yrs. 2 mos. 6 ds.*

If LESS than 1 day,

....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,  
(State or Country),

## 10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER,  
(State or Country),

## 12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ruth Lewis*(Address) *553 Bells St*

## 15-

Filed *FEB 26 1922*

ROBERT R. KRAUTER,

Burial Permit Clerk  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*Feb 24, 1922*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Feb 10 1922* to *2/24 1922*that I saw her alive on *Feb 21 1922*,and that death occurred, on the date stated above, at *2 P* m.

The CAUSE OF DEATH\* was as follows:

*Richells*

.....

.....

..... (Duration)..... yrs. .... mos. .... ds.

CONTRIBUTORY  
(Secondary)

..... (Duration)..... yrs. .... mos. .... ds.

(Signed) *E. H. H. H.* M. D.*2/25/22* (Address) *1010 E. 5th St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. .... mos. .... ds. In the State yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*mt Auburn Cem*

## 20-UNDERTAKER

*David Carlson*

## DATE OF BURIAL,

*Feb 25, 1922*

## ADDRESS

*916 Pa ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.







## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61703

## CERTIFICATE OF DEATH.

D 61703

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2451 Woodbrook St.: 93 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 2451 Woodbrook St.: 93 WARD)yrs., 9 mos., 9 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX 74-COLOR OR RACE, N5-SINGLE, Married  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word)6-DATE OF BIRTH: May 18, 1922

(Month)

(Day)

(Year)

7-AGE, 9yrs., 9 mos., 9 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,  
(State or Country), Ind10-NAME OF FATHER, Isid Kupchik11-BIRTHPLACE OF FATHER  
(State or Country), Russia12-MAIDEN NAME OF MOTHER, Mollie Klibnov13-BIRTHPLACE OF MOTHER  
(State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isid Kupchik(Address) 2451 Woodbrook

15-

Filed Feb 25 1922

191

ROBERT E. KRAITER  
Registrar.Burial Permit No. 51

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Feb 25, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 3, 1922, to Feb 25, 1922,that I saw her alive on Feb 25, 1922,and that death occurred, on the date stated above, at 19 m.

The CAUSE OF DEATH\* was as follows:

Broncho pneumonia(Duration) 4 yrs., 4 mos., 4 ds.CONTRIBUTORY  
(Secondary) Whooping cough(Duration) 21 yrs., 21 mos., 21 ds.(Signed) Dr. L. H. ... M. D.Feb 25, 1922 (Address) 2451 Woodbrook

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 9 yrs., 9 mos., 9 ds. In the State 9 yrs., 9 mos., 9 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Burial HomeDATE OF BURIAL, 2-26, 192220-UNDERTAKER Jack Lewis 1439 E. Baltimore

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61704

CERTIFICATE OF DEATH.

100-001  
D 61704

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. 8 Monument

ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Singer

(a) RESIDENCE. No. 1715 1/2 Monroe

(Usual place of abode)

ST.: WARD.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos.

ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE 7 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Morris Singer

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Sarah Scherr

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Jhenis 1439 E. Balt St (Address)

15 Filed FEB 26 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1921, to Feb 25, 1922, that I last saw her alive on Feb 25 12:30 P.M. 1922, and that death occurred, on the date stated above, at 2:45 a. m. The CAUSE OF DEATH\* was as follows:

Pneumo-pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY Brain Abscess (Secondary)

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 12/13/21

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ernest Edlaertch, M. D.

2/25, 1922 (Address) Hebrew Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Mt Carmel

2/26 1922

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E. Balt St

D 61705

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

33 D 61705

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.: *10* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Max Steenberg*(a) RESIDENCE. No. *724 Euclid* ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *35* yrs. mos.How long in U. S., if of foreign birth? *35* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Max Steenberg*6 DATE OF BIRTH (month, day, and year) *1/18/72*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*50*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Clothmaking* *080*(b) General nature of industry, business, or establishment in which employed (or employer) *Tailor*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Russia*10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Russia*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Russia*

14

Informant (Address) *Jack Lewis 1439 58th St*

15

Filed *EB 26 1922*

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/24* 19 *22*

17

HEREBY CERTIFY, That I attended deceased from

*Jan 5*, 19 *22*, to *Feb 29*, 19 *22*.That I last saw him alive on *Feb 29*, 19 *22*.and that death occurred, on the date stated above, at *2:30 P. m.*

The CAUSE OF DEATH\* was as follows:

*Tuberculosis of Intestines*(duration) yrs. *2 1/2* ds.

CONTRIBUTORY (Secondary)

*Shock - Toxemia*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *In Balto.*Did an operation precede death? *Yes* Date of *2/23/22*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *J. Stanley**Gratill* M. D.

19

(Address) *2844 Clifton Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Whitman Road**2/26* 19 *22*

20 UNDERTAKER

ADDRESS

*Jack Lewis 1439 58th St*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



D 61706

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1030 N. Eden ST., 10 WARD)

## 2-FULL NAME

George J. Herwing

## (a) RESIDENCE NO.

1030 N. Eden

ST., \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 3 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced, HUSBAND of (or) \_\_\_\_\_

Isabella D. Herwing6 DATE OF BIRTH (month, day, and year) Oct 28 18507 AGE Years 71 Months 3 Days 26 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Building Superintendent

(b) General nature of industry, business, or establishment in which employed (or employer)

086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

## 10 NAME OF FATHER

Thomas Herwing

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Scotland

## 12 MAIDEN NAME OF MOTHER

Mary Holden

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md

## 14

Informant (Address)

Mrs Isabella D. Herwing  
1030 N. Eden St

## 15

Filed \_\_\_\_\_, 19

Serial Permit Clerk Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jul 22 192217 I HEREBY CERTIFY, That I attended deceased from Jul 4 1922 to Jul 22 1922that I last saw him alive on Jul 22 1922and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH\* was as follows:

Arteriosclerosis  
Myocarditis  
Endocarditis  
Chronic(duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

arteriosclerosis  
chronic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? no(Signed) George Schilling, M. D.(Address) 428 W. Lombard St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Landon Park Cemetery

DATE OF BURIAL

July 27 1922

20 UNDERTAKER

George Schilling & Sons

ADDRESS

1126 E. Monument St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

15-2381707

## HEALTH DEPARTMENT—CITY OF BALTIMORE, 001

## CERTIFICATE OF DEATH.

REGISTERED NO. 100 D 61707

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 D 61707 ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME John W. Ritter

(a) RESIDENCE NO. 1240 134 100

(Usual place of abode)

WARD 100 D 61707

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 74

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

Job

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

John W. Ritter

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary E. Ritter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant (Address)

15

Filed FEB 20 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb. 21 1922, to Feb. 22 1922,

that I last saw him alive on Feb. 21 1922, and that death occurred, on the date stated above, at 7 30-15 m.

The CAUSE OF DEATH\* was as follows:

Emphysema -

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Bronchopneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Baltimore Md.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E. Bowles Andrews, M. D.

, 19 (Address) Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Olaf Cemetery

DATE OF BURIAL

2/26 22

20 UNDERTAKER

William Cook

ADDRESS

502 E. New

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT-CITY OF BALTIMORE

## CERTIFICATE OF DEATH

61708

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

1407 Gausson

ST. 34 WARD)

2-FULL NAME

Peter Sakowski

(Residence in Baltimore: No.

1407 Gausson Dr

St. 50 yrs. mos. ds.)

REGISTERED No. 61708

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male. 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Married (If write the word)

6-DATE OF BIRTH Oct 6, 1857 (Month) (Day) (Year)

7-AGE 64 yrs. 4 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Laborer. (b) General nature of industry, business, or establishment in which employed (or employer) General.

9-BIRTHPLACE (State or country) Germany.

10-NAME OF FATHER Mathew Sakowski

11-BIRTHPLACE OF FATHER (State or country) Germany.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna R. Sakowski

(Address) 1407 Gausson

15-FEB 26 1922

Filed 191

ROBERT R. KESTER,

Burial Permit Clerk,

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH February 25, 1922 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Jan 24, 1922, to Feb 25, 1922.

that I saw him alive on Jan 24, 1922.

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

Contributory Bronchitis (probable) (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) J. H. 79 Slemons M. D. 2/25, 1922 (Address) 2878 Stuyvesant Rd

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Cathedral Bm

DATE OF BURIAL

Feb 28, 1922

20-UNDERTAKER

William Cook

ADDRESS

502 E North St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61709

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *841. S. Dallas* ST.: *3* WARD)

## 2-FULL NAME

*Helena Wojcik.*

## (a) RESIDENCE. NO.

*841. S. Dallas*

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced (Write the word)

*Single.*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*July 20-1921*

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*9 3*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Pol.*

## 10 NAME OF FATHER

*Antoni Wojcik*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Poland.*

## 12 MAIDEN NAME OF MOTHER

*Wiktoria Ogazowska*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Poland*

## 14

Informant

(Address)

*Antoni Wojcik**841. S. Dallas. St.*

## 15

*FEB 26 1922*

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*Feb. 24 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*Feb 21, 1922, to Feb 25, 1922*that I last saw him alive on *Feb 25, 1922*and that death occurred, on the date stated above, at *4:00 p.m.*

The CAUSE OF DEATH\* was as follows:

*ant. gastr. int. ext.*

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. W. Anderson*, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Holy Rosary.**2/26 1922*

## 20 UNDERTAKER

## ADDRESS

*William Gielgowski 14148 Eastern**Valentin*

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61710

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61710

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pennington Ave. near Olive St.  
City of BALTIMORE: (No. Curtis Bay. St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
2-FULL NAME Joseph Domisiewicz, or Jos. Domins.  
(Residence in Baltimore: No. 105 Olive St. Curtis Bay. St. yrs. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 4-COLOR OR RACE, 5-Single, Married, Widowed, or Divorced, (Write the word.)  
Male, White, Married

6-DATE OF BIRTH, December 20th. 1874. 1.  
(Month) (Day) (Year)

7-AGE, 47 yrs. 2 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Car repairer, 073  
(b) General nature of industry, business, or establishment in which employed (or employer), B. & O. R. R. Co.

9-BIRTHPLACE, (State or Country), Poland.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER, (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Adella Domisiewicz, (wife)

(Address) 105 Olive St. Curtis Bay.

15-ROBERT R. KRAUTER,

FILED FEB 26 1922

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 21st. 1922. 192.  
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held no. Autopsy & Inquest (Inquest, autopsy or inquiry.)  
thereof and from the evidence obtained by said Autopsy & Inquest, and that said deceased came to a death on the day stated above.

The CAUSE OF DEATH\* was as follows:  
Internal Hemorrhage, Fracture of 2, 3, 4 & 5 ribs, right side, Laceration of Lung. Struck by an Automobile.  
Homicide. (Duration) yrs. mos. ds.

CONTRIBUTOR (Secondary) (Duration) yrs. mos. ds.  
(Signed) E. M. Bernhardt, M. D. (Coroner.)  
Feb. 24, 1922 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).  
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Holy Cross & Co. Feb. 27, 1922

ADDRESS

William F. Grogan, 1416 E. Eastern Ave.

## Homicide

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*,

*peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

*Abortion*, *Hemorrhage*, *Meningitis*, *Phlebitis*,  
*Cellulitis*, *Gangrene*, *Miscarriage*, *Pyemia*,  
*Childbirth*, *Gastritis*, *Necrosis*, *Septicemia*,  
*Convulsions*, *Erysipelas*, *Peritonitis*, *Tetanus*.

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved): *Suicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Pechel(a) RESIDENCE. NO. UnknownST. 76 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds.How long in U. S., if of foreign birth? 47 yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Widowed</u>
----------------------	---------------------------------	--

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofUnknown6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
<u>59</u>	<u>--</u>	<u>--</u>	<u>--</u>	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Germany10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Unknown14 Informant Hospital Records,(Address) Municipal Hospital.15 Filed FEB 26 1922 ROBERT R. KRAUTER,

Burial Permit Clerk,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 19 22

17

I HEREBY CERTIFY, That I attended deceased from  
February 23, 1922, to February 24, 1922  
that I last saw him alive on February 24, 1922  
and that death occurred, on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH\* was as follows:

Chronic nephritis(duration) 10 yrs. mos. ds.

CONTRIBUTORY

Syphilis; Hypertension  
(duration) 20 yrs. mos. ds.18 Where was disease contracted  
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Claydon Neil M. D.2/24/1922 Address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Trinity Street CemeteryFeb 27 19 22

20 UNDERTAKER

Geo Leimbach Son

ADDRESS

647 W. B. Ave.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

61711

38

61711

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61712

CERTIFICATE OF DEATH.

94-002  
D 61712

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 N. Howard ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. 718 N Howard ST., 11 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death alt 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 74 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St Marys Co Md (State or country)

10 NAME OF FATHER John Hall Key

11 BIRTHPLACE OF FATHER (city or town) St Marys Co Md (State or country)

12 MAIDEN NAME OF MOTHER Juliet Reeder

13 BIRTHPLACE OF MOTHER (city or town) St Marys Co Md (State or country)

14 Informant Maria Reeder Key (Address) 718 N. Howard

15 FEB 26 1922 ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1922, to Feb 25, 1922, that I last saw her alive on Feb 23, 1922, and that death occurred, on the date stated above, at 4:25 p.m.

The CAUSE OF DEATH\* was as follows:

Chronic bronchitis  
and catarrhal jaundice  
jaundice  
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Advanced age  
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) Chas. S. Keller, M. D.

Feb 25 (Address) 222 W. Monument St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Chapin St Marys Co. Md

20 UNDERTAKER

John F. Denny

DATE OF BURIAL

Feb 27 1922

ADDRESS

715 Light St



MARGIN RESERVED FOR BINDING  
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bls.

61713

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. *Manchester apt 14* ST.: *14* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

*William Robinson*

(a) RESIDENCE. NO.

*Madison Ave. Bloom St*

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *38* yrs. mos. ds. How long in U. S., if of foreign birth? *38* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male White*

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Selma Robinson*

6 DATE OF BIRTH (month, day, and year)

*Unknown*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*85*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired 045*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Dry Goods Merchant*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Birmingham England*

10 NAME OF FATHER

*Lezarus Robinson*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*England*

12 MAIDEN NAME OF MOTHER

*Dorothy*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*England*

14

Informant (Address)

*Selma Robinson Manchester apt 14*

15

*FEB 26 1922* *ROBERT R. KRAUTER* Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 23* 192*2*

17

I HEREBY CERTIFY, That I attended deceased from *Feb. 1*, 19*22*, to *Feb 23*, 19*22*.

that I last saw him alive on *Feb. 23*, 19*22*.

and that death occurred, on the date stated above, at *12* m.

The CAUSE OF DEATH\* was as follows:

*Arterio-sclerosis*

(duration) *3* yrs. mos. ds.

CONTRIBUTORY *Broncho-pneumonia* (Secondary)

(duration) *3* yrs. mos. ds.

18 Where was disease contracted

If not at place of death? *No*

Did an operation precede death? *No* Date of *No*

Was there an autopsy? *No*

What test confirmed diagnosis? *Clinical*

(Signed) *J. Frederick Lutz*, M. D.

*2-24-1922* (Address) *2040 Eutan Place*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Balto Hebrew Cem* *2/26 1922*

20 UNDERTAKER *J. AHRENS & CO.*

ADDRESS

FUNERAL DIRECTORS AND EMBALMERS

131 MADISON AVENUE

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

ST.,

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Feb 16<sup>th</sup>, 1922, to Feb 25<sup>th</sup>, 1922,that I last saw him alive on Feb 20<sup>th</sup>, 1922,

and that death occurred, on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH was as follows:

Hydrocephalus  
congenital

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

. 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 26 1922

Burial Permit Clerk.

in Penn. R.R. Henry G. O'Neill

Monawanda N.Y. Henry W. Means &amp; Son 805 N. Calver St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 61715  
PLACE OF DEATH

170  
REGISTERED NO. C 61715

CITY OF BALTIMORE (No. *University Hospital* ST. *14* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Frank Feldman*

(Residence in Baltimore: No. *240 Laurens St.*

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widower*  
(Write the word.)

6-DATE OF BIRTH, *Jan. 12, 1887*  
(Month) (Day) (Year)

7-AGE, *65 yrs. 1 mos. 23 ds.* If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *Musician*  
(b) General nature of industry, business, or establishment in which employed (or employer), *086*

9-BIRTHPLACE, (State or Country), *Balt. city*

10-NAME OF FATHER, *Sam. Feldman*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER, *Katherine Ruike*

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank Feldman Jr.*

(Address) *818 Harlem Ave.*

15-FEB 26 1922 ROBERT R. KRAUTER,

Filed. 101. Serial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb. 25, 1922*  
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.)

And that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Bullet wound in brain from a pistol in his own hands a few hrs.*  
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY *Suicide*  
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *H. H. Garrison* M. D.  
(Coroner.)

*2126, 122* (Address) *117 W. Saratoga St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, *Adam's Rest* DATE OF BURIAL, *Feb 27, 1922*

20-UNDERTAKER *William H. E.* ADDRESS *1734 K. Ave.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 61716

D 61716

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 Hollins ST. 19 WARD)2-FULL NAME Albert Conrad Stolzenbach

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 1626 Hollins ST. 19 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 11 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 14 - 1889

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2811

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto.10 NAME OF FATHER Amad A. Stolzenbach

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto.12 MAIDEN NAME OF MOTHER William A. Ray

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto.

14

Informant (Address)

Conrad A. Stolzenbach  
1626 Hollins St

15

FEB 26 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 22, 1922, to Feb 25, 1922that I last saw him alive on Feb 25, 1922and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH\* was as follows:

Brain hemorrhage(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Microscopic exam(Signed) Walter A. Cox, M. D.(Address) 541 Fulton St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Cemetery Feb 27 1922

20 UNDERTAKER

ADDRESS

George L. Schmitt 2101 E. 1st Ave

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Former* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day-laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or ~~as probably~~ such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Primary*

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

10.61717 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.61717

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 343 S. Chester ST. 1 WARD)

2-FULL NAME

(a) RESIDENCE. No. 343 S. Chester ST. 1 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 26-1920

7 AGE Years 1 Months 9 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Joseph Hare

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Helen Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15 Filed

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 20, 1922, to Feb 23, 1922

that I last saw him alive on Feb 23, 1922

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia (duration) yrs. mos. ds.

CONTRIBUTORY Dilated heart (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

(Address) 134 S. Ellwood Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Catholic Cemetery 2-27-22

20 UNDERTAKER

ADDRESS

J. G. Moran E. B. Burt

D 61718

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61718

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Municipal Hospital (Bay View)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.: 14 WARD)

2-FULL NAME

Esther Monroe

(a) RESIDENCE. No.

Bay View 571 Laurel ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced (write the word)

S!

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1884

7 AGE

Years

Months

Days

If LESS than 1 day.....hrs. or.....min.

38

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

67

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

Unknown

(State or country)

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

Unknown

(State or country)

14

Informant (Address)

Nep Reedors

15

File

FEB 27 1922

ROBERT N. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-25-1922

17

I HEREBY CERTIFY, That I attended deceased from

1-17-1922, to 2-25-1922

(that I last saw him alive on 2-22-1922)

and that death occurred, on the date stated above, at 5:45 A.M.

The CAUSE OF DEATH\* was as follows:

Chronic nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocardial insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed)

Clyde Monroe

M. D.

26, 1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn Bur

Feb 27 1922

20 UNDERTAKER

Daniel Easton

ADDRESS

916 Ba au

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE  
D 61719 113 D 61719

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *University Hospital*  
CITY OF BALTIMORE: (No. *Green & Lombard* ST.: *17* WARD)  
2-FULL NAME *Lillian Harris*  
(a) RESIDENCE. No. *659 Bradley St.* ST.: \_\_\_\_\_ WARD: \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. *4* mos. \_\_\_\_\_ ds. How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *infant*  
5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) *Oct 4, 1921*  
7 AGE Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. *4 22*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

*Hospital Records*  
**FEB 27 1922**

ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 25, 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Feb 23*, 19 *22*, to *Feb 25*, 19 *22*, that I last saw *her* alive on *Feb 25*, 19 *22*, and that death occurred, on the date stated above, at *2:10 P.m.*  
The CAUSE OF DEATH\* was as follows:

*Acute Gastro-Enteritis*

(duration) yrs. \_\_\_\_\_ mos. *6* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted *659 Bradley St.* if not at place of death?

Did an operation precede death? *no* Date of \_\_\_\_\_

Was there an autopsy? *no*

What test confirmed diagnosis? *Signs & Symptoms*  
(Signed) *Geo. E. Wells* M. D.  
, 19 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*MT Auburn Ave*

*Feb 27 1922*

20 UNDERTAKER

ADDRESS

*Daniel E. Eber*

*916*



61720

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE,

White

## 5-SINGLE,

MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

Married

## 6-DATE OF BIRTH,

Apr.

7

1850

(Month)

(Day)

(Year)

## 7-AGE,

71 yrs., 10 mos., 19 ds.

If LESS than 1 day.

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Home

9-BIRTHPLACE,  
(State or Country),

Ind

## 10-NAME OF FATHER,

John Cox

11-BIRTHPLACE OF FATHER  
(State or Country),

Ind

## 12-MAIDEN NAME OF MOTHER

Elizabeth Kirby

13-BIRTHPLACE OF MOTHER  
(State or Country),

Ind

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. Edwin Davis

(Address)

Glengyle Ave

## 15-

Filed FEB 27 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

2

26

1922

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Feb. 10 1922, to Feb. 26 1922,

that I saw him alive on Feb. 26 1922,

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic Bright's  
Active Sclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

Apoplexy

(Duration) yrs. mos. ds.

(Signed) E. H. Beeton M. D.

2.26.1922 (Address) Int. Washington

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

## DATE OF BURIAL

Arund Ridge

Mar. 1, 1922

## 20-UNDERTAKER

## ADDRESS

George J. Smith

Fayette St.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 317 S. Spring ST. 3 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 317 S. Spring St St. Lt yrs. 1 mos. 20 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE,

Adone5-SINGLE,  
MARRIED,  
WIDOWED,  
OR SEVERED.  
(Write the word.)  
Widow

## 6-DATE OF BIRTH.

Jan 15, 1857  
(Month) (Day) (Year)

## 7-AGE.

85 yrs. 1 mos. 20 ds.  
If LESS than 1 day,  
...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer  
0409-BIRTHPLACE.  
(State or Country),Maryland

## 10-NAME OF FATHER,

Molly Jackson11-BIRTHPLACE OF FATHER  
(State or Country),Maryland

## 12-MAIDEN NAME OF MOTHER

not known13-BIRTHPLACE OF MOTHER  
(State or Country),Maryland

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles E. Jackson(Address) 317 S. Spring St

## 15-

FEB 27 1922  
Burial Permit Clerk

ROBERT R. KRAUTER,

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

February 25, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Jan 5 1922, to Feb 25 1922,that I saw him alive on February 24 1922,and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH\* was as follows:

Alumina(Duration) 1 yrs. 1 mos. 20 ds.CONTRIBUTORY  
(Secondary)Chronic Intestinal Nephritis  
(Duration) 1 yrs. 1 mos. 20 ds.(Signed) Richard J. Slinger M. D.Feb 26 1922 (Address) 1514 S. Baltimore

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 1 mos. 20 ds. In the State 1 yrs. 1 mos. 20 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Cesbury

## DATE OF BURIAL,

Feb 28, 1922

## 20-UNDERTAKER

John W. Henderson

## ADDRESS

1502 E. Monument St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_ ST.: \_\_\_\_\_ WARD) \_\_\_\_\_

2-FULL NAME

*Ethel Stains*

(a) RESIDENCE. NO.

*Lutherville md R2D#1*

(Usual place of abode)

Length of residence in city or town where death occurred

*Unknown*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Oct. 6th 1921*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*4**20*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Maryland*

10 NAME OF FATHER

*Christian Stains*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Maryland*

12 MAIDEN NAME OF MOTHER

*Margaretta Fish*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Maryland*

14

Informant (Address)

15

*FEB 27 1922**ROBERT R. KRAUTER,*

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 26th 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan. 27th*, 19*22*, to *Feb. 26th*, 19*22*, that I last saw *her* alive on *Feb. 26th*, 19*22*, and that death occurred, on the date stated above, at *1:19 P. m.*

The CAUSE OF DEATH\* was as follows:

*Diphtheria, (not dysentery)*(duration) yrs. *1* mos. *14* ds.

CONTRIBUTORY (Secondary)

*Bronchopneumonia*(duration) yrs. mos. *3* ds.

18 Where was disease contracted

if not at place of death?

*Lutherville md*

Did an operation precede death?

Date of

Was there an autopsy?

*no*

What test confirmed diagnosis?

(Signed) *T.B. Gay*, M. D.19 (Address) *Johns Hopkins Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Solero Cemetery*

DATE OF BURIAL

*Feb 28 22*

20 UNDERTAKER

*Johns Burial Soc*

ADDRESS

*Towson*

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE CAREFULLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

61723

CERTIFICATE OF DEATH.

D 61723

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 ST., 19 WARD)

2. FULL NAME Mildred Vukcevic

(a) RESIDENCE No. 401 S Morris ST., New Jersey WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 27 1922

7 AGE Years 4 Months 13 Days 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Stevy Vukcevic

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Stevy Vukcevic (Address) 401 S. Morris St

15 FEB 27 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 19 22

17 I HEREBY CERTIFY, That I attended deceased from

, 19 22, to Feb 28, 19 22, that I last saw him alive on Feb 27, 19 22.

and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH\* was as follows: over

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stevy Vukcevic, M. D.

, 19 22 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park

20 UNDERTAKER

A. Jones

DATE OF BURIAL

Feb 28 19 22

ADDRESS

207 S. Stricker St



ANNA BOMERT,

## HEALTH DEPARTMENT—CITY OF BALTIMORE

001 61724

D 61724

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1624 Thames

ST. 15 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Bomert.

(a) RESIDENCE. NO. 16247 Thames

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 12 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female. 4 COLOR OR RACE White. 5 Single, Married, Widowed, or Divorced (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Romond Bomert.

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE Years 45 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Honor wife of 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Bawolwing Poland.

10 NAME OF FATHER John Wroblewski.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland.

12 MAIDEN NAME OF MOTHER Mary Kierowski.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland.

14

Informant (Address)

Romond Bomert.  
1624 Thames St.

15

FEB 27 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/27 1922

17 I HEREBY CERTIFY, That I attended deceased from 2-23, 1922, to 2-24, 1922,

that I last saw her alive on 2-24, 1922,

and that death occurred, on the date stated above, at 7:00 p.m.

The CAUSE OF DEATH\* was as follows:

Labor Pneumonia

(duration) yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary)

Heart failure

(duration) yrs. 2 mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Serum &amp; S. aggl.

(Signed) Wm. A. Rutledge, M. D.

45, 1911 (Address) 1624 Thames St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Stanislaus Cem.

Feb 28, 1922

20 UNDERTAKER

ADDRESS

M. F. Sadowski.

705 S. Ave.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rhs.

D 61725

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-5001  
D 61725

1. PLACE OF DEATH

CITY OF BALTIMORE; (No. 145 W. Ostend ST. 23 WARD)

2. FULL NAME

Charles E. Wheatley

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

145 W. Ostend

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Augusta Wheatley

6 DATE OF BIRTH (month, day, and year)

June 12-1866

7 AGE

57

Years

Months

8

Days

12

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Marble cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Hilgartner Bros.

9 BIRTHPLACE (city or town)  
(State or country)

Md.

10 NAME OF FATHER

Charles Wheatley

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

md.

12 MAIDEN NAME OF MOTHER

Mulkenaw

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

md.

14

Informant  
(Address)

Augusta Wheatley  
145 W. Ostend St.

15

FEB 27 1922

ROBERT K. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 24 1922

17

HEREBY CERTIFY, That I attended deceased from

Feb. 19, 1922, to Feb. 24, 1922.

that I last saw him alive on Feb. 24, 1922.

and that death occurred, on the date stated above, at 4:40 p.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary pneumonia

CONTRIBUTORY  
(Secondary)

(duration)

ys.

mos.

ds.

(duration)

ys.

mos.

ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical

(Signed)

J. J. H. M. D.

Feb. 24, 1922 (Address) 1 E. Lombard St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Woodlawn

DATE OF BURIAL

Feb 27 1922

20 UNDERTAKER

F. A. Krause & Son

ADDRESS

703 Hanover

D 61726

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No.

St.: 55 yrs. 6 mos. 25 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

FEB 27 1922

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

to

that I saw her alive on

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH\* was as follows:

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) M. D.

2/25, 1922 (Address), Franklin St. Hospital

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the 55 yrs. 6 mos. 25 ds. State

Where was disease contracted, if not at place of death? 1130 Nanticoke St.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park

Feb 28, 1922

20-UNDERTAKER

ADDRESS

Mrs. J. W. Trefel &amp; Son 501 W. Fayette

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61727

## CERTIFICATE OF DEATH.

129 D 61727

## 1-PLACE OF DEATH

## REGISTERED NO.

CITY OF BALTIMORE: (No. 2523 Worthington Blvd. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Ruth V. Cole

## (a) RESIDENCE. NO.

2523 Worthington Blvd.

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 8 mos. c

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced (write the word)

Female white Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Edward A. Cole

## 6 DATE OF BIRTH (month, day, and year)

June 25 1875

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

46

8

c

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

## 10 NAME OF FATHER

Lemuel Gejer

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore

## 12 MAIDEN NAME OF MOTHER

May Anne Cross

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

## 14

Informant

(Address)

Edward A. Cole  
2523 Worthington Blvd.

## 15

Filed

19

ROBERT A. KRAUTER

Registrar

FEB 27 1922

Burial Permit Clerk.

## 16 DATE OF DEATH (month, day, and year)

Feb 24 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Sept 1 1922 to Feb 24 1922

that I last saw him alive on Feb 24 1922

and that death occurred, on the date stated above, at 8 30 m.

The CAUSE OF DEATH\* was as follows:

Chronic Intestinal Apathy

(duration) yrs. 6 mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. 7 ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Charles M. Kieffer, M. D.

Feb 25 1922 (Address) Monroeville, Pa.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

London Park Cemetery

Feb 27 1922

## 20 UNDERTAKER

## ADDRESS

for foerdens, Son

217 S. Bca

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



D 61728

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61728

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *5602 Reisterstown Rd* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Dora C. Osborne*(a) RESIDENCE. No. *5602 Reisterstown St* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *27* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *B. W. Osborne*6 DATE OF BIRTH (month, day, and year) *Jan 28 1889*7 AGE Years *33* Months *1* Days *0* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Sylversville Ind*10 NAME OF FATHER *August Kruger*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Don't Know*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore*14 Informant *B. W. Osborne* (Address) *5602 Reisterstown Rd*15 Filed *19*

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 24* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *Feb. 15*, 19*22*, to *Feb 24*, 19*22*.that I last saw her alive on *Feb 24*, 19*22*.and that death occurred, on the date stated above, at *7:30* m.

The CAUSE OF DEATH\* was as follows:

*Myocarditis*  
*about 3 mo.*  
(duration) yrs. mos. ds.  
CONTRIBUTORY *acute dilatation of heart*  
(Secondary) (duration) yrs. mos. ds. *2 hrs.*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *physical*  
(Signed) *W. S. Tibbitts*, M. D.  
*2/24/22* (Address) *2220 Garrison Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Woodlawn Cemetery* *Feb 27 1922*

20 UNDERTAKER ADDRESS

*Jos. Friedlens & Son* *217 S. Pac.*

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MORE ~~001~~  
100 ~~D~~ 61729

D 61729

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 3713 York Road ST. 1 WARD. 1  
(Usual place of abode) (If none, give nearest relative)

Length of residence in city or town where death occurred 32 yrs. 4 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1922

17 I HEREBY CERTIFY, That I attended deceased from  
Feb'y 10<sup>th</sup>, 1922, to Feb'y. 26<sup>th</sup>, 1922  
that I last saw him alive on Feb'y. 26<sup>th</sup>, 1922  
and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Broncho-pneumonia

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)  
(State Country) *Breda*

12 MAIDEN NAME OF MOTHER *Harris & Harris*

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14 Informant *Louis Greensman*  
(Address) *643 E. Pass St.*

15 Filed 19 FEB 27 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk

(duration) — yrs. — mos. 21 da

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. da

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? *No* Date of

Are there an autopsy?

What test confirmed diagnosis?

(Signed) Herbert T. Ackerman, M. D.

19 (Address) 1227 H. J. Adams & Co. Ltd.

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

[illegible]

Mount Olivet Cemetery 192

20 UNDERTAKED	ADDRESS
1	
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for President Don 2178.06

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 61730

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 61730

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1119 Argyle Ave. ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Mapp

(a) RESIDENCE. NO. 1119 Argyle Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced

(or) WIFE of

Annie E. Mapp

6 DATE OF BIRTH (month, day, and year) Mar. 25-1875

7 AGE Years 46 Months 11 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labour 040

(b) General nature of industry, business, or establishment in which employed (or employer)

General

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Va.

10 NAME OF FATHER

William Mapp

11 BIRTHPLACE OF FATHER (city or town)

Va.

12 MAIDEN NAME OF MOTHER

Maggie Dittus

13 BIRTHPLACE OF MOTHER (city or town)

Va.

14

Informant (Address)

Annie E. Mapp 1119 Argyle Ave

15

FEB 27 1922

ROBERT R. KRASTEN

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1922, to Feb. 24, 1922,

that I last saw him alive on Feb. 24, 1922,

and that death occurred, on the date stated above, at 11:30 p. m.

The CAUSE OF DEATH\* was as follows:

Asphyxia

(duration) yrs. mos. ds. 14

CONTRIBUTORY (Secondary)

congestion of lungs (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Thymic

(Signed) Edward J. McCallister, M. D.

4/26 1924 Address 1230 Second Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

W. C. Culver Cemetery

DATE OF BURIAL

Feb 27 1922

20 UNDERTAKER

Geo. M. Johnson

ADDRESS 1234

Acting SA

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Probably pulmonary  
tuberculosis*



Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61731

## CERTIFICATE OF DEATH.

78 D 61731  
REGISTERED NO.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital

ST. 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Knight

(a) RESIDENCE. NO. Unknown

(Usual place of abode)

ST. Life WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos.

ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 66 -- --

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,  
(State or country) Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown  
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)

14 Informant Hospital Records,  
(Address) Municipal Hospital

15 Filed 19 Burial Permit Clerk

FEB 27 1922

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23 19 22

17 I HEREBY CERTIFY, That I attended deceased from December 8, 19 19, to February 23, 19 22.

that I last saw him alive on February 23, 19 22.

and that death occurred, on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH\* was as follows:

Epilepsy (idiopathic)  
(duration) 35 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) --- yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles McNeil M. D.

2/25/22 Address Municipal Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Linden Park

DATE OF BURIAL

2/28 19 22

20 UNDERTAKER

William Cook

ADDRESS

11/1/22

Spec. - 1-10-21-M&T-1500 Bks.

61732

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 61732

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2405 Fairlane, 1 WARD)

2. FULL NAME Robert R. Gough

(a) RESIDENCE No. 2405 Fairlane, 1 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of Anne E. Gough (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8 1866

7 AGE Years 56 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Can Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hartford Conn

10 NAME OF FATHER Robert R. Gough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hartford Conn

12 MAIDEN NAME OF MOTHER Anna Schuler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Md

14 Informant (Address) Anne E. Gough 2405 Fairlane

15 FEB 27 1922 Filed

ROBERT R. KRAUTER, Registrar

502 E. Pratt St.

MEDICAL CERTIFICATE OF DEATH

1. DATE OF DEATH (month, day, and year) Feb 24 1922

I HEREBY CERTIFY, That I attended deceased from Nov 1 1921, to Feb 24 1922, that I last saw him alive on Feb 22 1922, and that death occurred, on the date stated above, at 6 25 00 m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Stomach

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. M. McAvoy M. D.

Feb 25 1922 Address 839 S. Ellwood Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE DATE OF BURIAL

20 UNDERTAKER William C. 502 E. Pratt St.

Every item of information should be stated EXACTLY. PHYSICIANS should state exact statement of OCCUPATION. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61733

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5340 Winner Ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Flenner Pearson

(a) RESIDENCE. No. 5340 Winner Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 6 1922

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Md

10 NAME OF FATHER Jos. M. Pearson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md

12 MAIDEN NAME OF MOTHER Mary J. Benson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Md

14 Informant Jos. M. Pearson (Address) 5340 Winner Ave

15 Filed FEB 27 1922 ROBERT S. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1922, to Feb 26, 1922, that I last saw him alive on Feb 24, 1922, and that death occurred, on the date stated above, at 10-45 A.M.

THE CAUSE OF DEATH\* was as follows: Congenital Debility Foramen Ovale, not Closed (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? (Signed) W. L. Fair, M. D., 19 (Address) 12 E. 20th St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Not Olivet DATE OF BURIAL Feb 27 1922

20 UNDERTAKER Robt J. Turner Inc 1442 N Broadway ADDRESS

PHYSICIANS should state carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61734

90 D 61734

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1111 Penna. Ave. ST. 17 WARD)

2-FULL NAME

Prich Harris

(Residence in Baltimore: No. 1111 Penna. Ave.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

15 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male 4-COLOR OR RACE, colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, unknown, 1877 (Month) (Day) (Year)

7-AGE, 45 yrs., mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Barber (b) General nature of industry, business, or establishment in which employed (or employer), 804

9-BIRTHPLACE, (State or Country), New Jersey

10-NAME OF FATHER, L. L. Knowlton

11-BIRTHPLACE OF FATHER (State or Country), New Jersey

12-MAIDEN NAME OF MOTHER, K. M. Knowlton

13-BIRTHPLACE OF MOTHER (State or Country), New Jersey

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Mrs. Prich Harris

(Address), 1111 Penna. Ave.

15-

FEB 27 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 25, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

organic heart disease

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Feb. 26, 1922 (Address) 3802 Springdale St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem DATE OF BURIAL, Feb 27, 1922

20-UNDERTAKER, David E. Egan ADDRESS 916 Pe ar



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61735

## CERTIFICATE OF DEATH.

100-001  
D 61735

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 S. Collington Ave. 1st WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dolores Catherine Wolf

(a) RESIDENCE NO. 309 S. Collington Ave. 1st WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 29, 1910

7 AGE 1 Years 1 Months 25 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

10 NAME OF FATHER Edward Louis Wolf

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anita Catherine Kallhof

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Edward Louis Wolf (Address) 309 S. Collington Ave.

15 FEB 27 1922 ROBERT S. KRAUTER, Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26, 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1922, to Feb 25, 1922.

that I last saw her alive on Feb 25, 1922.

and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. L. Fox, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Oak Lawn

DATE OF BURIAL

Feb 28, 1922

20 UNDERTAKER

A. H. Hamann

ADDRESS

3200 Brook

THIS IS A PERMANENT RECORD. IT SHOULD BE CAREFULLY PRESERVED. IT IS THE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT INFORMATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61736

## CERTIFICATE OF DEATH.

REGISTERED NO. C 61736

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Wm H Scott*)ST.; *18* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *909 Puerce*)St.; *Wm H Scott* mo. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*Male*

4-COLOR OR RACE,

*C.*5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)*Married*

6-DATE OF BIRTH,

*Unborn*; 1

(Month)

(Day)

(Year)

7-AGE,

*66*

yrs. mos. da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

*Inspector 040*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country),

*Not Known*

10-NAME OF FATHER,

*Not Known*

11-BIRTHPLACE OF FATHER

(State or Country),

*Not Known*

12-MAIDEN NAME OF MOTHER

*Not Known*

13-BIRTHPLACE OF MOTHER

(State or Country),

*Not Known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Joseph Scott*(Address) *909 Puerce st*

15-

FEB 27 1922

ROBERT H. KRAUTER

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Feb 25, 1922*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Feb 22, 1922*, to *Feb 25, 1922*,that I saw him alive on *Feb 24, 1922*,and that death occurred, on the date stated above, at *8:10 a.m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Disease*  
*Heart (atherosclerosis)*

(Duration) yrs. mos. da.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. da.

(Signed)

*Feb 27, 1922* (Address) *909 Puerce st*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

*St. Auburn*

DATE OF BURIAL,

*2/27/22, 1922*

20-UNDERTAKER

*Sam. W. Chase*

ADDRESS

*1400. Asher*

AGE should be stated EXACTLY. Exact statements be properly classified. See instructions on back of certificate.

D 61737

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61737

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *9* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Joe P. Murrell*(a) RESIDENCE. NO. *1002 E. Lamar* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *47* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Mrs. Murrell*6 DATE OF BIRTH (month, day, and year) *1876*7 AGE Years *47* Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Letter Carrier*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country) *MD.*10 NAME OF FATHER *Patience Murrell*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Ireland*12 MAIDEN NAME OF MOTHER *Caroline Aspell*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Ireland*14 Informant *Miss Mary K. K. K.*(Address) *Lamar & Green St.*15 *FEB 27 1922* ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 25 22*

17

I HEREBY CERTIFY, That I attended deceased from *2/24* 19 *22*, to *2/25* 19 *22*, that I last saw him alive on *2/25* 19 *22*, and that death occurred, on the date stated above, at *2:40 P.* m.

The CAUSE OF DEATH\* was as follows:

*Acute fatty degeneration  
nephritis with uraemia*(duration) yrs. mos. *3* da.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted  
If not at place of death? *1002 E. Lamar St.*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physical findings*(Signed) *W. B. Jones* M. D.*2/25* 19 *22* Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*New Cathedral Cemetery* *Feb 28 22*

20 UNDERTAKER ADDRESS

*George J. Ruth 1735 Hayford Ave.*

EXACT COPY OF DEATH CERTIFICATE TO BE FILED IN PLAIN ENVELOPE, SEE INSTRUCTIONS ON BACK OF CERTIFICATES. CASE OF DEATH IN PLAIN ENVELOPE, SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Probably chronic.*  
*No further history.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61738

61738

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 Park Ave ST. 11 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

(a) RESIDENCE NO. 616 Park Ave ST. 11 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Lifetime ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

about 82 Years Months Days

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto.

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

unknown

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

unknown

14

Informant (Address)

Sister Superior  
616 Park Ave

15

Filed

FEB 27 1922J. E. Helm Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1922

17 I HEREBY CERTIFY, That I attended deceased from

July 25, 1922, to death, 1922.that I last saw him alive on July 25 1922and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? From - non-bacterial - rapid culture(Signed) Charles O. Moran, M. D., 19 (Address) 5-8 East St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Cathedral Cemetery2/28 1922

UNDERTAKER

Chas. F. Wauke & Son 118 W. North Royal Ave

D 61739

## HEALTH DEPARTMENT—CITY OF BALTIMORE

31

D 61739

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4501 Maine ave ST. 28 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Greer Miller

(a) RESIDENCE No. 4501 Maine ave.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of Robert F. Miller

6 DATE OF BIRTH (month, day, and year) Apr. 15, 1885

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

46

3

10

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

John A. Greer W. Va.

10 NAME OF FATHER

John A. Greer

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Va.

12 MAIDEN NAME OF MOTHER

Jennie E. Pope

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Va.

14

Informant

Robert F. Miller

(Address)

4501 Maine ave.

15

Filed

FEB 27 1922

J. E. Miller

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1922

17

I HEREBY CERTIFY, That I attended deceased from

1922 to July 25, 1922,

that I last saw her alive on July 25, 1922,

and that death occurred, on the date stated above, at 8:50 P. m.

The CAUSE OF DEATH\* was as follows:

Laryngeal Tuberculosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 5 yrs. mos. ds.

18 Where was disease contracted

if not at place of death? No

Did an operation precede death? No

Date of

Was there an autopsy? No

What test confirmed diagnosis? Ex. specimen

(Signed)

J. M. Delany Thomas, M. D.

25, 1922 (Address) 330 W. Charles st.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Havdawn Cemetery July 28, 1922

John O. Mitchell 1201 N. Fayette

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61740

## CERTIFICATE OF DEATH.

D 61740

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2441 Woodbrook Ave 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jannie Masserman(a) RESIDENCE. NO. 2441 Woodbrook Ave WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced Widowed (or) WIFE of Solomon Masserman

6 DATE OF BIRTH (month, day, and year)

7 AGE 69 Years Months Days If LESS than 1 day,    hrs. or    min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife(b) General nature of industry, business, or establishment in which employed (or employer)   (c) Name of employer   9 BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Henry Kaufman11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Don't know13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)14 Informant Solomon Masserman (Address) 2441 Woodbrook Ave15 Filed FEB 27 1922 J. K. Kohn Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25th 192217 I HEREBY CERTIFY, That I attended deceased from Feb 25th, 1922, to Feb 25th, 1922.that I last saw her alive on Feb 25th, 1922.and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH\* was as follows:

Diabetes Melitus(duration) 2 yrs.    mos.    ds.CONTRIBUTORY (Secondary) (duration)    yrs.    mos.    ds.18 Where was disease contracted 2441 Woodbrook Ave if not at place of death?Did an operation precede death? No Date of   Was there an autopsy? NoWhat test confirmed diagnosis? Chemical & Microscopical(Signed) August Horn, M. D.Feb 24 1922 (Address) 40 E 25th St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oheb Shalom Cem DATE OF BURIAL 27th 192220 UNDERTAKER J. Adams Co ADDRESS 1611 Madison Ave

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

D 61741

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61741

## CERTIFICATE OF DEATH.

101-001

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Murray Hospital

ST.

19

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

George Lippey

(a) RESIDENCE. NO.

1516 McHenry

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life

yrs.

mos.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

Nov 14, 1894

7 AGE

Years

Months

Days

If LESS than

27

3

13

1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Huckster 345

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md

10 NAME OF FATHER

George Lippey

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Matilda

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant (Address)

Murray Hosp. Records

G. E. W. W. W.

J. E. W. W.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 24, 1922, to Feb 27, 1922,

that I last saw him alive on Feb 27, 1922,

and that death occurred, on the date stated above, at 12 40 a. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY Acute Pul. Oedema

(Secondary) Cardiac Failure (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death?

No

Was there an autopsy?

Yes

What test confirmed diagnosis? Findings signs &amp; symptoms

(Signed) Stanley Grubill M. D.

, 12 (Address) 2044 Clifton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Union

March 1 1922

20 UNDERTAKER

ADDRESS

H. H. Witzke

1531 W. Lombard St.

TION is very important. See instructions on back of certificates.



D 61742

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61742

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 1247

ST. 24 WARD

## 2-FULL NAME

Warren B. Bryant

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE. NO. 1247

Battery Ave. ST. 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos.

ds. How long in U. S., if of foreign birth?

yrs. mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

M

## 4 COLOR OR RACE

W

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Aug 14 1907

## 7 AGE

14 Years

6 Months

10 Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Northumberland Co Va

## 10 NAME OF FATHER

Wallace B. Bryant

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Northumberland Co Va

## 12 MAIDEN NAME OF MOTHER

Annie Johnson

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Northumberland Co Va

## 14

Informant (Address)

Mrs Wallace Bryant 1247 Battery Ave

## 15

Filed FEB 27 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

2. 24

1922

## 17

I HEREBY CERTIFY, That I attended deceased from

10. 4, 1922, to 2. 24, 1922,

that I last saw him alive on 2. 24, 1922,

and that death occurred, on the date stated above, at 10.5 a. m.

The CAUSE OF DEATH\* was as follows:

myocarditis, dilatative  
of heart &  
nephritis

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Chronic nephritis

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. J. Durlington, M. D.

245. 1922 (Address) 102 E Fort Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Catholics

## DATE OF BURIAL

2/27 1922

## 20 UNDERTAKER

J. J. Durlington

## ADDRESS

1318 E. Light St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61743

## CERTIFICATE OF DEATH.

22 D 61743

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 200 Church St. ST., 25 WARD)

## 2-FULL NAME

Carroll Dushane Bramlich

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

200 Church St., Antio Bay ST.,

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 5 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

M.

## 4 COLOR OR RACE

W.

## 5 Single, Married, Widowed, or Divorced (write the word)

single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

X

## 6 DATE OF BIRTH (month, day, and year)

Sept. 24, 1919

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

253

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Infant

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

## 10 NAME OF FATHER

Chas. B. Bramlich

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Freda Dangelert

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

## 14

Informant (Address)

Freda Bramlich  
200 Church St. - Antio Bay

## 15

Filed

FEB 27 1922ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb. 27 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb. 16, 1922, to Feb. 27, 1922.that I last saw him alive on Feb. 26, 1922.and that death occurred, on the date stated above, at 3:20 a.m.

The CAUSE OF DEATH\* was as follows:

Polionmyelitis (acute)(duration) yrs. mos. 12 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

XDid an operation precede death? no Date of XWas there an autopsy? noWhat test confirmed diagnosis? X

(Signed)

Geo. B. Davis, M. D.427, 1922 (Address) 211 Church St., Antio Bay.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Edgar Hill Co.2/28 1922

UNDERPAKER

ADDRESS

1318 High St.

D 61744

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61744

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *24* ST. *24* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. *1459 Stevenson* ST. *24* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,

or Divorced (write the word)

*Female White Widowed*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Widowed*

6 DATE OF BIRTH (month, day, and year)

*Dec. 7, 1869*

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*52 2 19*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housework.*

(b) General nature of industry, business, or establishment in which employed (or employer)

*obo*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Balto.,  
Md.*

10 NAME OF FATHER

*Harry Phillips*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Englan d.*

12 MAIDEN NAME OF MOTHER

*Jane Williamson*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Scotland*

14

Informant  
(Address)*Mercy Hospital Recd.*

15

Filed

FEB 27 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb. 26, 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 20*, 19*22*, to *Feb 26*, 19*22*that I last saw her alive on *Feb. 26*, 19*22*and that death occurred, on the date stated above, at *6:15 A.M.*

The CAUSE OF DEATH\* was as follows:

*(1) Diphtheria & Cellulitis  
of right hand &  
throat*(duration) *(1) ?* yrs. *(2) 7* mos. *4* ds.CONTRIBUTORY (Secondary) *Septicemia*(duration) *(1) ?* yrs. *(2) 4* mos. *4* ds.

18 Where was disease contracted

if not at place of death?

*Home*

Did an operation precede death?

Date of *Feb 21 1922*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *John J. Quinn*, M. D.(Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Bedford Hill**2/28 1922*

20 UNDERTAKER

ADDRESS

*H. B. Warle**115 E. McVey*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH  
CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *24* WARD) REGISTERED NO. *113*  
2-FULL NAME *Ruth Reidy*  
(a) RESIDENCE, No. *1216 Hull* ST. *24* WARD.  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. *5* mos. *11* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sept. 15, 1921*

7 AGE Years *5* Months *11* Days *11* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto. Md*  
(State or country)

10 NAME OF FATHER *Frank Reidy*

11 BIRTHPLACE OF FATHER (city or town) *Md*  
(State or country)

12 MAIDEN NAME OF MOTHER *Sarah Evans*

13 BIRTHPLACE OF MOTHER (city or town) *Md*  
(State or country)

14 Informant *Mercy Hospital Record*  
(Address)

15 *FEB 27 1922*

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 26 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Feb 17 1922* to *Feb 26 1922*, that I last saw her alive on *Feb 26 1922*, and that death occurred, on the date stated above, at *10:30 P. m.*  
The CAUSE OF DEATH\* was as follows:

*Catarrhal Enteritis*

(duration) yrs. mos. ds.  
CONTRIBUTORY *Toxemia*  
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted *Home*  
if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed *Signs & symptoms*

(Signed) *John F. Burns* M. D.

, 19 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Grav. Per. Cemetery* *Feb 28 1922*

20 UNDERTAKER ADDRESS

*Mrs. C. E. Evans* *1428 B. Ave.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE 61746

61746

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 Stiles St. ST. 3 WARD)

2-FULL NAME Baby Miss (Rossino)

(a) RESIDENCE. NO. 911 Stiles St. ST. 3 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, write the word Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Feb 26-22

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Michael Rossino

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Maria Rossino

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14

Informant (Address) Michael Rossino 911 Stiles St.

15

FEB 27 1922

ROBERT E. KRAUTER,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 19 22

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1922, to Feb 26, 1922, that I last saw him alive on Feb 26, 1922, and that death occurred, on the date stated above, at 11:40 P.M.

The CAUSE OF DEATH\* was as follows:

Transverse dehiscence of intestines contracted Pelvic (duration) yrs. mos. ds. CONTRIBUTORY (Secondary) Right off left of heart (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. L. Valentine, M.D.

Address 211 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincent's Cem.

DATE OF BURIAL Feb. 27, 1922

20 UNDERTAKER

ADDRESS

Wendell Shippey &amp; Son 27 S. Calvert

CAUSE OF DEATH in plain terms, so that it may be understood by the layman. See instructions on back of certificates.

George Rickler (Recklein)  
HEALTH DEPARTMENT—CITY OF BALTIMORE

REGISTERED No. C

PLACE OF DEATH  
CITY OF BALTIMORE (No. 61747)

2-FULL NAME

(Residence in Baltimore: No. 61747)

CERTIFICATE OF DEATH.

ST. 76 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male  
4-COLOR OR RACE White  
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)  
6-DATE OF BIRTH unknown, 1 (Month) (Day) (Year)

7-AGE 87 yrs., mos. ds.  
If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer). Unknown

9-BIRTHPLACE (State or Country). Germany

10-NAME OF FATHER unknown

11-BIRTHPLACE OF FATHER (State or Country) unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country) unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) McCary

(Address) Bayview Hospital

15- FEB 27 1922 ROBERT H. KRAUTER

Filed. 191. Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH February 21, 1912 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.)

investigation and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Intra Cranial Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fall downstairs

(Duration) yrs. mos. ds.

(Signed) Phineas T. P. M. D.

(Address) 1800 N. Broadway

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

HOPKINS HOSPITAL

20-UNDERTAKER ADDRESS

FEB 21 1922

Baltimore, Md.,

1/27

1927

## TO THE COMMISSIONERS OF HEALTH:

We hereby make application to have the city bury the body  
 of George Ree Klein, age 87 color W,  
 at this Hospital, No. Bay View Hosp Street, and in  
 died here 7/21 1922 Death cert. furnished directly by  
 H N residence is Wolfe & Alexianna Sts  
 We notified Jacob Bennett of his death at that address  
 and can get no response. Will not return

Surgeon in charge

Bay View

Geo R McKeen M.

Hospital

peritoneum, etc., Carcinoma, Sarcoma, etc., of  
 ..... (name origin; "Cancer" is less definite;  
 void use of "Tumor" for malignant neoplasms);  
 Measles; Whooping cough, Chronic valvular heart  
 disease; Chronic interstitial nephritis, etc. The con-  
 tributory (secondary or intercurrent) affection need  
 not be stated unless important. Example: Measles  
 disease causing death), 10 ds.; Broncho-pneu-  
 monia (secondary), 10 ds. Never report mere  
 symptoms or terminal conditions, such as "As-  
 tenia," "Anemia," (merely symptomatic), "At-  
 phy," "Collapse," "Coma," "Convulsions," "De-  
 lity," ("Congenital," "Senile," etc.), "Dropsy,"  
 "Exhaustion," "Heart Failure," "Hemorrhage,"  
 "Hemiparesis," "Marasmus," "Old Age," "Shock,"  
 "Frenia," "Weakness," etc., when a definite dis-  
 ease can be ascertained as the cause. Always  
 specify all diseases resulting from child birth or  
 scarring, as "PUERPERAL septicemia," "PUER-  
 AL peritonitis," etc. State cause for which sur-  
 gical operation was undertaken. For violent  
 THIS STATE MEANS OF INJURY and qualify as  
 ACCIDENTAL, SUICIDAL, HOMICIDAL, or as probably  
 h, if impossible to determine definitely. Ex-  
 ples: Accidental drowning; Struck by railway  
 n—accident; Revolver wound of head—homi-  
 cide; Poisoned by carbolic acid—probably suicide.  
 nature of the injury, as fracture of skull, and  
 sequences (e. g. sepsis, tetanus) may be stated  
 er head of "Contributory."  
 certificates will be returned for additional in-  
 formation which may give any of the following  
 ases, without explanation as the sole cause of  
 h:  
 Hemorrhage, Meningitis, Phlebitis,  
 villitis, Gangrene, Miscarriage, Pyemia,  
 birth, Gastritis, Necrosis, Septicemia,  
 usions, Erysipelas, Peritonitis, Tetanus.  
 The following must be referred to a Coroner:  
 deaths due to accident (if criminal negligence  
 bly involved): Suicides, Homicides, Abortions  
 (induced), whether death is directly or indirectly  
 o same.

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 61748

D 61748 CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanley LipinskiSeamen's Union Bethel Mission,(a) RESIDENCE. NO. Bethel and Aliceanna Sts. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.How long in U. S., if of foreign birth Unknown mos.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day. hrs. or min.
	33			

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town)  
(State or country)Poland10 NAME OF FATHER John Lipinski11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Poland12 MAIDEN NAME OF MOTHER Mary Goglitzen13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Poland14 Informant Hospital Records  
(Address) H.T.H.15 FEB 27 1922 ROBERT R. KRAUTER,  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23, 192217 I HEREBY CERTIFY, That I attended deceased from  
Feb. 21, 1922 to Feb. 23, 1922,  
that I last saw him alive on Feb. 23, 1922,  
and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(duration) Unknown mos. ds.CONTRIBUTORY Tuberculous broncho(Secondary) pneumonia (duration) yrs. mos. ds. 14 ds.18 Where was disease contracted  
If not at place of death? UnknownDid an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? Autopsy, X-ray(Signed) Francis J. Padayachee, M.D.(Address) Municipal Tbc. Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

Commissioner Health,FEB 27 1922



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61749

## CERTIFICATE OF DEATH

900 D 61749

1-PLACE OF DEATH

Municipal Hospital (Pay Day)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME

Harry Ashman

(a) RESIDENCE

No. 1329 N. Stockton St

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

da.

How long in U. S., if of foreign birth?

yrs.

mos.

da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

Cal

5 Single, Married, Widowed, or Divorced (write the word)

1

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

?

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

38

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

?

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

R. P. Leard

JOHNS HOPKINS HOSPITAL

15

FEB 27 1922

ROBERT K. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-23-1922

17 I HEREBY CERTIFY, That I attended deceased from 2-23-1922 to 2-23-1922

that I last saw him alive on 2-23-1922

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Dr. McNeill

M. D.

2-26-1922 Address

Municipal Hospital (Pay Day)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF 1922

JOHNS HOPKINS HOSPITAL

FEB 27 1922

20 UNDERTAKER

ADDRESS

Commissioner Health

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61750

D 61750

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

50 yrs.

mos.

ds.

ST. WARD.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

Wh

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of (or WIFE of)

John Lauterbach

6 DATE OF BIRTH (month, day, and year)

Apr. 14-1856

7 AGE

63

Years

Months

10

Days

12

If LESS than 1 day. hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

C. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Eastley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14 Informant (Address)

John Lauterbach  
419 S. Pulaski St.

15 Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 26 1922

17

I HEREBY CERTIFY, That I attended deceased from

2-22-22, 19, to 2-26, 1922,

that I last saw her alive on 2-26-22, 19

and that death occurred, on the date stated above, at 7:45 p.m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of mediastinum and glands of neck.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocardial Infarct.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. C. Caldwell, M. D.

19 (Address) St. Agnes Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Paul's Cemetery Mar 1 1922

20 UNDERTAKER

ADDRESS

Geo. Schwab North Baltimore

27 1922

Burial Permit Clerk.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

OLD 61751

D 61751

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

Maple Hill  
Balls Road + 37th.

ST.

WARD)

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## 2-FULL NAME

Dorothy Poole Thompson

## (a) RESIDENCE. NO.

Balls Road + 37th

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed,

or Divorced (write the word)  
Widow

## 5a If married, widowed, or divorced

(or) WIFE of

George W. Thompson

## 6 DATE OF BIRTH (month, day, and year)

July 16-1848

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

73 7 10

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Lady

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

at Home

(c) Name of employer

## 9 BIRTHPLACE (city or town)

Baltimore

(State or country)

Md.

## 10 NAME OF FATHER

Robert Poole

## PARENTS

## 11 BIRTHPLACE OF FATHER (city or town)

Ireland.

(State or country)

## 12 MAIDEN NAME OF MOTHER

Ann Simpson

## 13 BIRTHPLACE OF MOTHER (city or town)

Washington  
D.C.

(State or country)

## 14

Informant  
(Address)Robert V. Simpson  
Balls Road + 37th

15 1922

Robert P. Harrison,

Registrar

Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb 26

1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Nov. 14<sup>th</sup>

1921

to Feb 26

1922.

that I last saw her alive on Feb 26

1922.

and that death occurred, on the date stated above, at 9.45 p. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(duration) — yrs. 3 mos. 12 ds.

CONTRIBUTORY  
(Secondary)

Arteriosclerosis

(duration) 20 yrs. — mos. — ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed)

Chas. G. Hill

M. D.

, 19 (Address)

Wylie

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Druid Ridge

2-28 1922

## 20 UNDERTAKER

## ADDRESS

H. W. Harrison &amp; Sons Co

The Baltimore Sun

D 61752

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61752

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE (No. *337 Font Hill Rd*)

WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

(a) RESIDENCE NO. *337 Font Hill Rd*

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *1* yrs. *6* mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*4 COLOR OR RACE *W*5 Single Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *11/17/20*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *John A. Fisher*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore*12 MAIDEN NAME OF MOTHER *Ann M. Quinn*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore*

PARENTS

14

Informant (Address) *John A. Fisher*

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *February 25* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from *June 25*, 19*21*, to *Feb 24*, 19*22*, that I last saw him alive on *"*, 19*22*, and that death occurred, on the date stated above, at *3 9* m.The CAUSE OF DEATH<sup>a</sup> was as follows:*Incompetence*  
*Congenital atelectasis*

CONTRIBUTORY (Secondary)

(duration) *1* yrs. *6* mos. ds.(duration) yrs. mos. ds. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Edw. J. Coolahan* M. D.*2/27/22* (Address) *24 N. Fulton Ave*<sup>a</sup>State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

*London Park*  
*J. J. Fisher**2/28/22*  
*1318 Light St*



D 61753

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61753

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 N. Fairmount Ave. ST.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1511 N. Fairmount Ave. St.; 66 yrs., 7 mos., 21 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *F.* 4-COLOR OR RACE. *Col.* 5-SINGLE, *single* MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, *July 4, 1856*  
(Month) (Day) (Year)

7-AGE, *66 yrs., 7 mos., 21 ds.* If LESS than 1 day, ....hrs. or ....min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *House work*  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *MD.*

PARENTS.  
10-NAME OF FATHER, *Henry B. Robinson*  
11-BIRTHPLACE OF FATHER (State or Country), *MD.*  
12-MAIDEN NAME OF MOTHER, *Dorcas Thomas*  
13-BIRTHPLACE OF MOTHER (State or Country), *MD.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Josephine Robinson*  
(Address) *1511 N. Fairmount Ave.*

15- Robert P. Harrison,

27-1922 Burial Permit Clerk, Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb. 25, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *March 15, 1921*, to *Feb. 25, 1922*, that I saw her alive on *Feb. 24, 1922*, and that death occurred, on the date stated above, at *1 P.* m.  
The CAUSE OF DEATH\* was as follows:

*Elephantiasis*  
(Duration) *10 yrs., 11 mos., 11 ds.*  
CONTRIBUTORY *acute nephritis*  
(Secondary) (Duration) *4 mos., 4 ds.*

(Signed) *J. M. Hayes* M. D.  
*2/25, 1922* (Address) *513 N. Belvidere St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the ....yrs. ....mos. ....ds. State

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Laurel Cemetery* DATE OF BURIAL, *Feb. 28, 1922*

20-UNDERTAKER, *Charles Alexander* ADDRESS *721 N. Lombard*

D 61754

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61754

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH 253 E. Hamburg St.  
 CITY OF BALTIMORE: (No. Balto: md. ST. 24 WARD)

REGISTERED NO. \_\_\_\_\_  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel P. Moore

(a) RESIDENCE NO. 253 E. Hamburg St. ST. 24 WARD 24  
 (Usual place of abode) (If non-resident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) widower

5a If married, widowed, or divorced HUSBAND of Late Sarah P. Moore

6 DATE OF BIRTH (month, day, and year) Jan. 16-1853

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
69 1 10

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Walt-Chorman

(b) General nature of industry, business, or establishment in which employed (or employer) Obv

(c) Name of employer C. L. Apple Girth Co.

9 BIRTHPLACE (city or town) Balto: md.  
 (State or country)

10 NAME OF FATHER John L. Moore

11 BIRTHPLACE OF FATHER (city or town) Earls  
 (State or country) Pa.

12 MAIDEN NAME OF MOTHER Liza Bristow

13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
 (State or country)

14 Informant Emma L. Mahan  
 (Address) 253 E. Hamburg St. Balto: md.

15 Robert P. Harris  
 19 \_\_\_\_\_

Filed Feb 27 1922  
 Burial Permit Clerk Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 12 1922 to Feb 26 1922

that I last saw him alive on Feb 26 1922

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic nephritis

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) uricemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted \_\_\_\_\_  
 if not at place of death?

Did an operation precede death? No Date of \_\_\_\_\_

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. H. Campbell, M. D.

(Address) 1644 Hancock St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Reston Cemetery

DATE OF BURIAL Feb 28 1922

20 UNDERTAKER W. J. Schmitt

ADDRESS Walt He

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61755

61755

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Sq. Hospital*)

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *608 Nicoll Lane*)St.; *Life* yrs. *6* mos. *6* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

*May 20, 1857*  
(Month) (Day) (Year)

7-AGE

*84* yrs. *9* mos. *6* ds.

If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)*Bookkeeper*

9-BIRTHPLACE, (State or Country),

*Balto*

10-NAME OF FATHER,

*John W. Vaulant*

11-BIRTHPLACE OF FATHER (State or Country),

*Balto Md.*

12-MAIDEN NAME OF MOTHER

*Mary E. Norris*

13-BIRTHPLACE OF MOTHER (State or Country),

*Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Mrs. Mary Hoanell*

(Address)

*608 Nicoll Ave.*

15-

*Robert P. Harrison*

Filed.....

191.....

Registrar.

27 1922

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Feb 26, 1922*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Feb-19-1922*, to *Feb-26-1922*, that I saw him alive on *Feb-26-1922*, and that death occurred, on the date stated above, at *9 P. m.*

The CAUSE OF DEATH\* was as follows:

*Apoplexy*

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

*Newton S. Parr* M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the *64* yrs. *9* mos. *6* ds.

Where was disease contracted, if not at place of death?

*608 Nicoll Lane*

Former or usual residence

*608 Nicoll Lane*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Gowans Bros Cem**Mar 1, 1922*

20-UNDERTAKER

ADDRESS

*Wm. H. H. H. H.**North Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61756

## CERTIFICATE OF DEATH.

REGISTERED No. C

90 D 61756

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 801 Pennington Ave ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 801 Pennington Ave St. 4 yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male	4-COLOR OR RACE. White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married
6-DATE OF BIRTH. Jan 10, 1841 (Month) (Day) (Year)		
7-AGE. 81 yrs. 1 mos. 14 ds.		If LESS than 1 day. ...hrs. or...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Retired Ser. Captain		

9-BIRTHPLACE, (State or Country), Germany

PARENTS.	10-NAME OF FATHER, Henry Stindt
	11-BIRTHPLACE OF FATHER (State or Country), Germany
	12-MAIDEN NAME OF MOTHER unknown
	13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Stindt, Jr.  
(Address) 1007 Pennington Ave

15-

Robert P. Harrison,  
Filed 191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 24, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 13 1922, to Feb 24 1922, that I saw him alive on Feb 24 1922, and that death occurred, on the date stated above, at 9A m. The CAUSE OF DEATH\* was as follows:

Coronary Embolism  
Cardiac Thrombosis

(Duration) ... yrs. ... mos. 13 ds.

CONTRIBUTORY (Secondary)

(Duration) 5 yrs. ... mos. ... ds.

(Signed) Joseph A. Schuman, M. D.  
Feb 25 1922 (Address) 1076 Mad Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross, A.C.C. DATE OF BURIAL, Feb 28 1922

20-UNDERTAKER, Margaret S. Flynn ADDRESS, 422 High St

27 1922

Burial Permit Clerk



D 61757

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61757

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2954 Presstman

ST.: 16<sup>th</sup> WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. 2954 Presstman

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. — mos. — ds.

ST.: 16<sup>th</sup> WARD.

(If nonresident give city or town and State)

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a ~~Married~~, widowed, ~~divorced~~  
HUSBAND of  
(or) WIFE of

Wm B Langley

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

73

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore Md

10 NAME OF FATHER

John Brown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Denmark

12 MAIDEN NAME OF MOTHER

Julia A. Lynch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md

14

Informant

(Address)

Robt R Higgins  
2954 Presstman St

15

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1922

17 I HEREBY CERTIFY, That I attended deceased from

Dec 23<sup>rd</sup> 1921, to Feb 27<sup>th</sup> 1922that I last saw her alive on Feb 27<sup>th</sup> 1922

and that death occurred, on the date stated above, at 7:20 a. m.

The CAUSE OF DEATH\* was as follows:

Acute Myocarditis

CONTRIBUTORY (Secondary) (duration) yrs. mos. 7 ds.  
Chronic Interstitial Nephritis18 Where was disease contracted  
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) D. Edgar Ray, M. D.

427, 1927 Address 2919 Belmont Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn

March 1 1922

20 UNDERTAKER

ADDRESS

Geo W. Little

2700

Edmondson

271922

Burial Permit

D 61758 HEALTH DEPARTMENT—CITY OF BALTIMORE 002  
188- D 61758

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (N

2-FULL NAME

(Residence in Baltimore No.

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

7-AGE,

65 yrs..... mos..... ds.

If LESS than 1 day,

hrs. or..... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER,

(State or Country)

12-MAIDEN NAME OF MOTHER,

(State or Country)

13-BIRTHPLACE OF MOTHER,

(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

1922

Robert P. Harrison,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

1922 (Year)

17-

I HEREBY CERTIFY that I took charge of the

remains described above, held and (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) find that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH was as follows:

Accident

Fracture of Skull

(Duration) yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Signed) J. C. Blades, M. D.

(Address) 143 N. Broadway

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Cathedral Cemetery Jan. 25, 1922

20-UNDERTAKER, ADDRESS

Martin Maher & Son 1827 W. North Ave

27-1922 Burial Permit Clerk.

D 61759 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Church Home and Infirmary

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST., WARD)

2-FULL NAME

Mrs. Lillian Hale

(a) RESIDENCE NO.

Whitehouse, Md.

ST.,

WARD

Whitehouse Md.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

7

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

George M. Hale

6 DATE OF BIRTH (month, day, and year)

June 20, 1891

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

30

8

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

John Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Annie Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

George M. Burke  
White House, Md.

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27, 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1922, to Feb. 27, 1922.

that I last saw him alive on Feb. 27, 1922.

and that death occurred, on the date stated above, at 12.25 P.M.

The CAUSE OF DEATH\* was as follows:

General Peritonitis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 21

Was there an autopsy? Yes

What test confirmed diagnosis?

Autopsy - Operation

(Signed)

Raymond Partridge, M. D.

, 19

(Address)

Church Home and Infirmary

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

MOVAL

Mt Carmel Cemetery

19

20 UNDERTAKER

ADDRESS

E. Le Roy Stiffler

120 E. North Ave.

D 61760 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61760

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1048 Brentwood ST. WARD)

## 2-FULL NAME

William Bird Perry

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

1048 Brentwood ST.

## WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND or (or) WIFE of

Martha J. Perry

6 DATE OF BIRTH (month, day, and year)

May 20-1884

7 AGE

82

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Money Messenger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

William Perry

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Elizabeth

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia

14

Informant

(Address)

Dr. W. B. Perry

1048 Brentwood ST.

15

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 28 1922

17 I HEREBY CERTIFY, That I attended deceased from

Feb 22 1922, to Feb 27 1922

that I last saw him alive on Feb 26 1922

and that death occurred, on the date stated above, at 11:50 a.m.

The CAUSE OF DEATH\* was as follows:

Arterio-sclerosis

## CONTRIBUTORY

(Secondary)

(duration) 3 yrs. mos. ds.

Hypertensive degeneration

18 Where was disease contracted

if not at place of death?

1048 Brentwood ST.

Did an operation precede death?

in Date of

Was there an autopsy?

in

What test confirmed diagnosis?

Clinical

(Signed)

James M. Denton

M. D.

247 1922 (Address)

2008 Chase St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

BURYAL

Greenmount

DATE OF BURIAL

2/28 1922

ADDRESS

20 UNDERTAKER

William Cook

502 E. North St.

27 1922

Burial Permit Clerk.



D 61761

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61761

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1461 Reynolds Street. St. 7 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William E. Smith.

48 -- 8 -- 24.

(Residence in Baltimore: No. 2903 McElderry Street, St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

2-SEX Male. 4-COLOR OR RACE White. 5-Single, Married, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH June 2, 1873. (Month) (Day) (Year)

7-AGE 48 yrs. 8 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work U. S. Warehouse Inspector. (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or Country). Baltimore Md.

10-NAME OF FATHER Edward L. Smith.

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER Catherine Miller.

13-BIRTHPLACE OF MOTHER (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Fields. (daughter)

(Address) 2903 McElderry Street

15- Robert P. Harrison,

Filed 7 1922 Burial Permit Clerk. Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH February 27, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Valvular disease of the heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. M. A. Emhardt M. D. (Coroner.)

Feb. 27, 1922 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Baltimore Cemetery 3/1 1922

20-UNDERTAKER, ADDRESS

John A. Moran, 3000 E. Balto. St.

D 61762

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61762

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Light and West Streets. St. 22 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....Francis J. Schaffer.

50 -- 5 -- 9

(Residence in Baltimore: No. 42 E. York Street. St.; yrs. .... mos. .... ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, (Write the word.) Single.6-DATE OF BIRTH, September 17, 1871. 1. .... (Month) (Day) (Year)7-AGE, 50 yrs. 5 mos. 9 ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION (a) Trade, profession, or particular kind of work, Laborer. (b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), Baltimore Md.10-NAME OF FATHER, William Schaffer.11-BIRTHPLACE OF FATHER, (State or Country), Baltimore Md.12-MAIDEN NAME OF MOTHER, Annie Frisby.13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Schaffer. (sister-in-law).(Address) 1703 Marshall Street.15- Robert P. Harrison,Filed 1922 Registrar.71022 Partial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 26, 1922. 1922 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.)thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) And that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute Alcoholism.

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signature) W. M. Pinckard M. D. (Coroner.)Feb. 27, 1922. (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, .... yrs. .... mos. .... ds. In the State, .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

New Cathedral 2-28 1922

20-UNDERTAKER, ADDRESS

William Cook 502 E. North

D 61763

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61763

## CERTIFICATE OF DEATH.

Registered No. C.....

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 6 W. Lee Street. St. 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Julian W. Aydllett.

4

(Residence in Baltimore: No.

6 W. Lee Street.

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male. 4-COLOR OR RACE. White. 5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. June 17, 1878. 1. (Month) (Day) (Year)

7-AGE. 43 yrs. 8 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Carpenter. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). North Carolina.

10-NAME OF FATHER. Thomas Aydllett.

11-BIRTHPLACE OF FATHER. (State or Country). North Carolina.

12-MAIDEN NAME OF MOTHER. Mary Owens.

13-BIRTHPLACE OF MOTHER. (State or Country). North Carolina.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mattie A. Aydllett. (wife).

(Address) 763 W. Lexington St.

15- Robert P. Harrison, Registrar.

Filed 27 1922 Serial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. February 24th, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to his death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

Valvular disease of the Heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) H. M. Penhard, D. (Coroner.)

Feb. 27, 1922 (Address) 10.17 &amp; Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Western Cem 2-28 1922

20-UNDERTAKER. ADDRESS

William Cook 502 E. North

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61764

D 61764

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3033 St. Paul Street. ST. 12 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Emma A. Maurer.

## (a) RESIDENCE NO.

3033 St. Paul St.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? 25 yrs. --- mos. --- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female. 4 COLOR OR RACE White. 5 Single, Married, Widowed, or Divorced, (write the word) Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov, 3rd, 1867.

7 AGE Years Months Days If LESS than 1 day, hrs or min. 54 3 23

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Germany.

10 NAME OF FATHER August Maurer.

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Risman

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14

Informant Frieda Herbert. (sister).  
(Address) 4022 Walrad Ave.

15

Robert P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26, 19 22

17 I HEREBY CERTIFY, That I attended deceased from February 26, 1922, to February 26, 1922.

that I last saw her alive on February 26, 19 22.

and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH\* was as follows:

Organic disease of the Heart.

CONTRIBUTORY (Secondary) Bronchial Asthma.  
(duration) 4 yrs. --- mos. --- ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Otto M. Reinhardt, M. D.

Address 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral 2-1 19 22

20 UNDERTAKER

William Root 502 E. North

THIS IS VERY IMPORTANT

7-1922

Bristol Permit Clark



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61765

## CERTIFICATE OF DEATH.

129 D 61765  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4650 Kernwood Ave. ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 4650 Kernwood Ave. St. 50 yrs. mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female  
4-COLOR OR RACE. White  
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single (Write the word.)

6-DATE OF BIRTH. Sept 9, 1845  
(Month) (Day) (Year)

7-AGE. 76 yrs. 5 mos. da.  
If LESS than 1 day, ....hrs. or ....min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. At Home  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Baltimore Co.

10-NAME OF FATHER. Joel Matthews

11-BIRTHPLACE OF FATHER (State or Country). Balto Co.

12-MAIDEN NAME OF MOTHER. Sophia Hibberd

13-BIRTHPLACE OF MOTHER (State or Country). Carroll Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mathias Mathias

(Address) 4650 Kernwood Ave.

15-

Filed 7 1922 Robert P. Harrison, Registrar.

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb 26, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 6, 1921, to Feb 25, 1922, that I saw her alive on Feb 25, 1922, and that death occurred, on the date stated above, at 12-40 A.M.

The CAUSE OF DEATH\* was as follows:  
Cardiac Insufficiency accompanied with general dropsy.  
(Duration) yrs. 4 mos. da.

CONTRIBUTORY (Secondary) Nephritis  
(Duration) yrs. mos. da.

(Signed) E. H. Duncan M. D.  
Feb 26, 1922 (Address) 5106 York Road

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Friends Cemetery Sun. Land Co. Md.  
DATE OF BURIAL. Mar 2, 1922

20-UNDERTAKER. William Cook  
ADDRESS 502 E. North Ave.

## Chronic nephritis

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

*lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

*Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.*

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (if induced), whether death is directly or indirectly due to the same.

D 61766

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61766

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE (No.

616 Park Ave

ST.

WARD

2-FULL NAME

Sarah C. McGeer

(Residence in Baltimore: No.

416 Park Ave

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. 3 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widow

6-DATE OF BIRTH.

Feb. 22, 1840

7-AGE.

82 yrs., 4 mos., 4 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

unemployed

9-BIRTHPLACE.

(State or Country).

Balto. Md.

10-NAME OF FATHER.

John Straney

11-BIRTHPLACE OF FATHER

(State or Country).

Ireland

12-MAIDEN NAME OF MOTHER

Mary Delaney

13-BIRTHPLACE OF MOTHER

(State or Country).

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Maude J. Haug

(Address)

Calvert &amp; 30th St.

15-

Robert P. Harrison,

Burial Permit Clerk.

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Feb. 26, 1922

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, find that said deceased came to her death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

accidental asphyxiation by gas

(Duration) yrs. mos. ds.

CONTRIBUTORY.

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. T. Hennessy J. M. D.

(Coroner.)

Feb. 27, 1922 (Address) 2802 E. Madison Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Cemetery

DATE OF BURIAL,

2/28, 1922

20-UNDERTAKER

ADDRESS

Henry W. Mears &amp; Son 805 N. Calvert

important. See instructions on back of certificate.

8271922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61767

## CERTIFICATE OF DEATH.

D 61767

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1809 Eutaw Place

ST.: 14 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katharine Flannery

(a) RESIDENCE. NO. 1809 Eutaw Place

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 30 yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Patrick T. Flannery

6 DATE OF BIRTH (month, day, and year) Aug. 16, 1861

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 61 6 8

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Sykesville (State or country) Maryland

10 NAME OF FATHER Daniel Turney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Dowd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mr. Patrick T. Flannery (Address) 1809 Eutaw Place

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26, 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1922, to Feb. 26, 1922, that I last saw him alive on Feb. 26, 1922,

and that death occurred, on the date stated above, at 3:05 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic Endocarditis (mitral stenosis)  
Chronic Myocarditis, Angina Pectoris,  
Chronic Nephritis, Chronic Hepatitis

(duration) 2 yrs. 1 mos. ds.

CONTRIBUTORY Subacute Myocardial Infarction (Secondary)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual clinical &amp; laboratory tests

(Signed) M. B. Lewis, M. D.

19 (Address) The Walbert 1800 N. Calvert

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral Cemetery

2/28, 1922

20 UNDERTAKER

ADDRESS

Henry W. Mears &amp; Son 805 N. Calvert

27 1922



D 61768

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61768

## CERTIFICATE OF DEATH.

113

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 Marshall St.)

ST. 23 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. Huber

(a) RESIDENCE, No. 1618 Marshall St.

ST. WARD.

(If nonresident give city or town and State)

(Usual place of abode)  
Length of residence in city or town where death occurred yrs. 5 mos. 12 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

### MEDICAL CERTIFICATE OF DEATH

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX  
Female

4 COLOR OR RACE  
White

5 Single, Married, Widowed, or Divorced (write the word)  
Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 13 1921

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
5 12

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.  
(State or country)

10 NAME OF FATHER Lewis Huber

11 BIRTHPLACE OF FATHER (city or town) Md.  
(State or country)

12 MAIDEN NAME OF MOTHER Agnes La Mar

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.  
(State or country)

14 Informant Mr. Lewis Huber  
(Address) 1618 Marshall St.

Robert P. Harrison,

Registrar

281922

Burial Permit Clerk

16 DATE OF DEATH (month, day, and year) Feb 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1922, to Feb 25, 1922,

that I last saw him alive on Feb 25, 1922,

and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH\* was as follows:

Pericarditis Enteritis

CONTRIBUTORY (Secondary)

(duration)

yrs. mos. 4 ds.

Encephalitis

(duration)

yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

M. J. Campbell M. D.

(Address)

1644 Hancock St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Peters Cem.

DATE OF BURIAL

2/28 1922

ADDRESS

20 UNDERTAKER

J. F. McCall

130 E. Fort.

D 61769

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61769

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No.

562 Gold St.

ST.:

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Ethel Daniels

(Residence in Baltimore: No.

562 Gold St.

St.: yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE,

Caucasian

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)  
married

## 6-DATE OF BIRTH,

August 27, 1891.  
(Month) (Day) (Year)

## 7-AGE,

31 yrs., 5 mos., 30 ds.

If LESS than 1 day,  
...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular  
kind of work.....  
(b) General nature of industry, busi-  
ness, or establishment in which  
employed (or employer).....House work.  
0379-BIRTHPLACE,  
(State or Country),

Maryland

10-NAME OF  
FATHER,11-BIRTHPLACE  
OF FATHER  
(State or Country),12-MAIDEN NAME  
OF MOTHER13-BIRTHPLACE  
OF MOTHER  
(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanch Roy Jones

(Address) 1931 Drexel Hill Ave

## 15-

Robert P. Harrison,

Registrar.

Burial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Feb. 26, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the  
remains described above, held an  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said  
(Inquest, au-opsy and find that said deceased came to death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute Dilatation of heart  
5 minutes

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY AC. Gastro-Enteritis  
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) J. E. Harrison, M. D.  
(Coroner.)

Feb. 27, 1922 (Address) 2873 E. Broadway Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,  
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN-  
SIENTS, OR RECENT RESIDENTS).At place In the  
of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

## Former or usual residence.....

## 19-PLACE OF BURIAL OR REMOVAL, (DATE OF BURIAL,

Mt. Auburn Cem. Feb. 28, 1922

## 20-UNDERTAKER ADDRESS

George H. Hollenbeck 631 Drexel Hill Ave

D 61770

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61770

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 Newington Ave. 3 WARD)

## 2-FULL NAME

(a) RESIDENCE. NO. 712 Newington Ave. 3 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 24 mos. 24 ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 192217 I HEREBY CERTIFY, that I attended deceased from Feb 19 1922, to Feb 25 1922, that I last saw him alive on Feb 25 1922 at 11:30 a.m.and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH\* was as follows:

BronchopneumoniaCONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) 7 yrs. 2 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? none(Signed) Elinor B. Pinner M. D., 19 (Address) 412 Calhoun St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Roudon Park Cem. Feb 28 1922

ADDRESS

20 UNDERTAKER

Margaret G. Flynn 1422 Egl St.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

female white single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 2, 1860

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

62-24

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

housekeeper

9 BIRTHPLACE (city or town) (State or country)

Balto., Md.

10 NAME OF FATHER

Chas. Paul

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Louise Sandler

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto., Md.

14 Informant (Address)

Emma Paul 712 Newington Ave.

15

Robert F. Harrison, RegistrarBurial Permit Clerk

TION is very important. See instructions on reverse side.

D 61771

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61771

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 915 N. Broadway ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan M. Brendel(a) RESIDENCE. NO. 915 N. Broadway ST.: 7 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of John S. Brendel6 DATE OF BIRTH (month, day, and year) June 20-18837 AGE Years 88 Months 8 Days 6 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. Md. (State or country)10 NAME OF FATHER Charles S. Canoles11 BIRTHPLACE OF FATHER (city or town) Balto. Co. Md. (State or country)12 MAIDEN NAME OF MOTHER Ann Fuller13 BIRTHPLACE OF MOTHER (city or town) Balto. Co. (State or country)14 Informant Mrs. B. H. Purdum (Address) Hamilton15 Filed Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 192217 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to Feb 26, 1922, that I last saw him on Feb 26, 1922, and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Myocarditis & Atrial Insufficiency

CONTRIBUTORY

(Secondary)

Arterio Sclerosis and Interstitial Nephritis

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles J. Purdum, M. D.Address 4706 Hampden

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Miss Cemetery Feb. 28 1922

20 UNDERTAKER ADDRESS

Wm C. Black 927 N. Broadway

1922





D 61773

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61773

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 S. Patterson Park Ave. ST., 1 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Henrietta M. Lutz

(a) RESIDENCE NO. 120 S. Patterson Park Ave ST., WARD (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. Now long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John Phillip Lutz

6 DATE OF BIRTH (month, day, and year) Dec 13, 1932

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

89 2 13

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER Harry Häfner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Catherine Frank

(Address) 230 S. Broadway

15 Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 19 19 to Feb 26 1922

that I last saw her alive on Jan 19 1922

and that death occurred, on the date stated above, at 4 15 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic interstitial nephritis  
Myocarditis

(duration) 7 yrs. moa da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical Examination

(Signed) J. F. Rie, M. D.

Feb 27, 1922 (Address) 24 S. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Baltimore Cemetery

20 UNDERTAKER

H. Sander Sons

DATE OF BURIAL

Feb 28 1922

ADDRESS

1701 North St.

81922

Special Permit Case

D 61774

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61774

## CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *106 Oakley Ave*)

FULL NAME

(Residence in Baltimore: No. *106 Oakley Ave*)

ST.:

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs.. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*Male*

4-COLOR OR RACE,

*White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

*Married*

6-DATE OF BIRTH,

*Oct**29**1884*

(Month)

(Day)

(Year)

7-AGE,

*37**3**27*

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*Cashier*

9-BIRTHPLACE,

(State or Country),

*Maryland*

10-NAME OF FATHER,

*Jos. E. Paul*

11-BIRTHPLACE OF FATHER

(State or Country),

*Maryland*

12-MAIDEN NAME OF MOTHER

*Mary D. Paulsen*

13-BIRTHPLACE OF MOTHER

(State or Country),

*Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Robert P. Harrison*(Address). *106 Oakley Ave*

15-

*Robert P. Harrison,*

Filed

191

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Oct 27**1922*

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereon and from the evidence obtained by and

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Coronary thrombosis*  
*Accidental*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *John J. Harrison* W. D.

(Coroner.)

1922 (Address) *7602 R. Rd.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

*Druid Ridge Cem.**March 1, 1922*

20-UNDERTAKER

ADDRESS

*Joseph Syfer**1600 N. North St.*

important. See instructions on back of certificate.

D 61775

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61775

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1028 Borth ST., 18 WARD)

## 2. FULL NAME

Raymond S. Turner

(a) RESIDENCE NO.

1028 Borth

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 0 mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

10/22/21

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore

10 NAME OF FATHER

Otis Turner

11 BIRTHPLACE OF FATHER (city or town)

MA

(State or country)

12 MAIDEN NAME OF MOTHER

Gertrude Scott

13 BIRTHPLACE OF MOTHER (city or town)

MA

(State or country)

14

Informant  
(Address)Gertrude Turner  
1028 Borth St.

15

Robert F. Harrison,

19

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

2/27/22

17

I HEREBY CERTIFY, That I attended deceased from

2/26/22, 1922, to 2/27/22, 1922,that I last saw him alive on 2/26/22, 1922,and that death occurred, on the date stated above, at 8:10 A. m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of 2/27/22Was there an autopsy? NoWhat test confirmed diagnosis? Smear

(Signed)

Bernard J. Long

, M. D.

2/27/22

(Address)

910 W. Lombard

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Brown & Ireland  
Schneider

81922



**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Lobar Pneumonia*  
*No infection prior.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61776

D 61776

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 Calhoun ST., 16 WARD)2-FULL NAME Susan Bruce(a) RESIDENCE NO. 1621 Calhoun ST., 16 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. 0 mos. 0 ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) July 4 1872

7 AGE

Years

51?

Months

Days

824If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

070

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Cockeysville  
Md.10 NAME OF FATHER John Smith11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Md.12 MAIDEN NAME OF MOTHER Jennie Johnson13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Pa.

14

Informant  
(Address)Louis Bruce  
1621 Calhoun St15 1977 Robert P. Harrison,

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1922

17

I HEREBY CERTIFY, That I attended deceased from  
Feb 17, 1922, to Feb 26, 1922,that I last saw him alive on Feb 17, 1922, at 4 A. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Carcinoma of  
uterus(duration) 1 yrs. 0 mos. 0 ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Williams Tracy, M. D.2/27, 1922 (Address) 1928 Pa. Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

19

20 UNDERTAKER

ADDRESS

Mr. Claburn  
5783/1/22  
578

D 61777

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61777

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1635 Miller

ST. 7 WARD)

## 2. FULL NAME

(a) RESIDENCE NO. 1635 Miller

(Usual place of abode)  
Length of residence in city or town where death occurred 2 yrs. mos.ST. WARD  
(If non-resident give city or town and State)  
How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 5 - 1919

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Robert P. Hartison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1922

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1922, to July 27, 1922, that I last saw him alive on July 27, 1922, and that death occurred, on the date stated above, at 5:15 m.  
The CAUSE OF DEATH\* was as follows:

Capillary Bronchitis

CONTRIBUTORY (duration) yrs. mos. ds.  
(Secondary) (duration) yrs. mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

UNDERTAKER

DATE OF BURIAL

ADDRESS

D 61778

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61778

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Franklin* *James* *Hayes* *19* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *216 N. Stricker* St.; yrs..... mos..... ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Single*6-DATE OF BIRTH, *Jan* *15* *1921*  
(Month) (Day) (Year)7-AGE, *1* yrs. *1* mos. *11* ds. If LESS than 1 day, .... hrs. or .... min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *None*  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Bald City*10-NAME OF FATHER, *Armando Giuseppe*11-BIRTHPLACE OF FATHER, (State or Country), *Italy*12-MAIDEN NAME OF MOTHER, *Rena Carmela*13-BIRTHPLACE OF MOTHER, (State or Country), *Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mungio Girlanda*(Address) *406 Spalding*

15- Robert P. Harrison,

8-1922 1922 Burial Permit Clerk. Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb* *26* *1922*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Burns over body & face by slow match explosion accident*  
(Duration) .... yrs. .... mos. .... ds.CONTRIBUTORY *Inhalation* (Secondary)*James* (Duration) .... yrs. .... mos. .... ds.(Signed) *James W. Pearson* M. D. (Coroner.)*Feb 27 1922* (Address) *700 E. Chap*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, *Franklin* *James* *Hayes* *19* *216 N. Stricker* *7* yrs. .... mos. .... ds. State, .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

*216 N. Stricker*Former or usual residence *216 N. Stricker*19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer* DATE OF BURIAL, *Mar 1* *1922*20-UNDERTAKER, *J. Henry & Co* ADDRESS *2008 Blum*



D 61779

Filomena Grue.  
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61779

## CERTIFICATE OF DEATH.

Registered No. C.....

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Franklin Square Hospital* 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *214 N Stricker* St.; yrs. *10* mos. *10* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE. *White* 5-Single, Married, Widowed, or Divorced. *Married* (Write the word.)

6-DATE OF BIRTH. (Month) (Day) (Year)

7-AGE. *48* yrs. *10* mos. *10* ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Housewife* (b) General nature of industry, business, or establishment in which employed (or employer). *at home*9-BIRTHPLACE. (State or Country). *Italy*10-NAME OF FATHER. *Phillip C. Curren*11-BIRTHPLACE OF FATHER. (State or Country). *Italy*12-MAIDEN NAME OF MOTHER. *Rosario*13-BIRTHPLACE OF MOTHER. (State or Country). *Italy*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank Della Noce*  
(Address) *216 N Stricker St*

15-

Robert P. Harrison,

Filed

1922

Bureau Permit Clerk

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Feb. 26* 192*2*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *death* on the day stated above.The CAUSE OF DEATH\* was as follows:  
*3d Burns over whole body by stove boiler explosion accident*(Duration) yrs. *1* mos. *1* ds.CONTRIBUTORY (Secondary) (Duration) yrs. *1* mos. *1* ds.(Signed) *James M. Penlon* M. D. (Coroner.)*Feb. 26* 192*2* (Address) *700 E. Charles St*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents) At place *Stricker St* In the of death yrs. *1* mos. *1* ds. State yrs. *1* mos. *1* ds.

Where was disease contracted, if not at place of death?

*216 N Stricker St*  
Former or usual residence *216 N Stricker St*19-PLACE OF BURIAL OR REMOVAL. *Holy Redeemer Cem* DATE OF BURIAL. *Mar 1* 19*22*20-UNDERTAKER. *J. Henning* ADDRESS *2008 Alameda*

D 61780

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61780

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *908 Woodley*)ST. *161* WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *908 Woodley*)St.; yrs. mos. *2* da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE.

*W*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

## 6-DATE OF BIRTH.

*Feb 25, 1922*  
(Month) (Day) (Year)

## 7-AGE,

*1* yrs. *2* mos. *2* da.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE,

(State or Country), *Baltimore Md*

## 10-NAME OF FATHER.

## 11-BIRTHPLACE OF FATHER

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER

PARENTS.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

## 15-

Filed *1922* *Robert P. Harrison,* Registrar.

Serial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Feb 27, 1922*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Feb 25 1922, to Feb 27 1922,*  
that I saw him alive on *Feb 27 1922,*and that death occurred, on the date stated above, at *5:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Pressure*  
*at birth*  
(Duration) yrs. mos. da.

## CONTRIBUTORY.

(Secondary)

(Duration) yrs. mos. da.

(Signed)

*Joseph E. Moore* M. D.*Feb 27, 1922* (Address) *1520 Hollins St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

## DATE OF BURIAL.

## 20-UNDERTAKER

## ADDRESS

D 61781

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61781

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 307 Gwynn Avenue ST

WARD 20

## 2-FULL NAME

Josephine S. Wheat

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

307 Gwynn Avenue ST

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7 1906

7 AGE Years Months Days LESS than 1 day, hrs. or min. 15 9 19

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Student at school

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Francis Lee Wheat

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Ella A. West

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

Mrs. Ella A. Wheat 307 Gwynn Avenue

28 1922

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 1 1922, to February 26 1922, that I last saw him alive on February 26 1922, and that death occurred, on the date stated above, at 8:45 P.M. The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart Disease (Mitral Stenosis) (duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Oedema of the lungs (duration) 3 yrs. 3 ds.

18 Where was disease contracted if not at place of death?

Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm J. Harrison, M. D.

Address 1701 N. Union Avenue

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Wheaton

DATE OF BURIAL

2/28/22

20 UNDERTAKER

Martin Fahy &amp; Sons

ADDRESS

1827 N. North Ave

D 61782

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

10 D 61782

1-PLACE OF DEATH

(Arrived at Hospital dead.)

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST. 1

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Marie Drager

(a) RESIDENCE. No.

743 S. Curley St.

ST. 1

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 4 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

child

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 5, 1917

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4

4

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country)

10 NAME OF FATHER Joseph Drager

11 BIRTHPLACE OF FATHER (city or town) Md.  
(State or country)

12 MAIDEN NAME OF MOTHER Martha Wankowski

13 BIRTHPLACE OF MOTHER (city or town) Poland  
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL  
(Address) Robert F. Harrison,

15 Filed 28 1922 Registrar Parial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 1922.

17

I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1920, to March 1, 1920.

that I last saw her alive on March 1, 1920.

and that death occurred, on the date stated above, at 11:45 P. M.

The CAUSE OF DEATH\* was as follows:

Tracheotomy for diphtheria

(duration) 2 yrs. 1 mos. 11 ds.

CONTRIBUTORY Asphyxiation due to obstruction  
(Secondary) of tracheotomy tube

(duration) yrs. mos. ds.

18 Where was disease contracted home  
if not at place of death?

Did an operation precede death? yes Date of Jan. 14, 1920.

Was there an autopsy? No.

What test confirmed diagnosis? Examination of tube

(Signed) Horace G. Stewart, M. D.

Feb. 26, 1922 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Stanislaus Cem

DATE OF BURIAL

Feb 28 1922

20 UNDERTAKER

Lilly Geiler

ADDRESS

403 S. W. 1st St.



# CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Specimen of Dr. Jones' conversation with Dr. Stewart over phone. To be charged to diphtheria*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61783

D 61783

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(Residence in Baltimore: No.

ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 87 yrs., 5 mos., 17 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Feb 26, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 22, 1922, to Feb 26, 1922, that I saw her alive on Feb 26, 1922, and that death occurred, on the date stated above, at 2 P. m. The CAUSE OF DEATH\* was as follows:

Pulmonary Edema  
(Duration) yrs. 2 mos. 2 ds.  
CONTRIBUTORY Mitral Regurgitation  
(Secondary) (Duration) yrs. 4 mos. 4 ds.  
(Signed) Daniel Miller M. D.  
, 191... (Address) 1506 N. Broadway

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61784

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No.

St.: 50 yrs., — mos. — da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

## 4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

## 6-DATE OF BIRTH.

## 7-AGE.

If LESS than 1 day, — hrs. or — min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE, (State or Country),

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER (State or Country),

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER (State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

Filed

191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

## CONTRIBUTORY (Secondary)

(Signed)

2-27-22, 191... (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

## DATE OF BURIAL.

## 20-UNDERTAKER

## ADDRESS

D 61785

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61785

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1126 Calhoun*ST.: *16* WARD)

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Elizabeth Towns*

## (a) RESIDENCE. NO. ....

*1126 Calhoun*

ST. ....

WARD. ....

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *15* yrs. ....

How long in U. S., if of foreign birth? ....

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*F*

## 4 COLOR OR RACE

*C*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Married*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Jesse Towns,*

## 6 DATE OF BIRTH (month, day, and year)

*Dec. 5, 1894*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*27**2**20*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Domestic*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Chambermaid*

(c) Name of employer

*Mrs. H. P. Flowers 3008 Calver St.*

## 9 BIRTHPLACE (city or town) (State or country)

*Summerville Co., Va*

## 10 NAME OF FATHER

*William Corsey*

## 11 BIRTHPLACE OF FATHER (city or town)

*Va.*

## 12 MAIDEN NAME OF MOTHER

*Lucy Jones*

## 13 BIRTHPLACE OF MOTHER (city or town)

*Va*

## 14

Informant (Address)

*Lucy Gay Corsey 1126 Calhoun*

## 15

Date

*Robert P. Harrison,*

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *February 25, 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from *Jan 10, 1922, to Feb 25, 1922,*that I last saw her alive on *Feb 25, 1922,*and that death occurred, on the date stated above, at *11:35 P.* m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis*(duration) yrs. *6* mos. *?* ds.

## CONTRIBUTORY (Secondary)

*None*

(duration) yrs. .... mos. .... ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Sputum Examination*(Signed) *W. H. Wright*, M. D.Address *1309 Pratt St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Mt Zion**Feb 28, 1922*

## 20 UNDERTAKER

## ADDRESS

*Edward Piggold 1463 Carey*



D 61786

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61786

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Radecke Ave. near*

ST.,

WARD) *4 Raskenburg*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Annie J. Klein*(a) RESIDENCE NO. *Radecke Ave. near*

ST.,

WARD *Raskenburg*

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *John G. Klein*6 DATE OF BIRTH (month, day, and year) *May 28 1853*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*(b) General nature of industry, business, or establishment in which employed (or employer) *at home*

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto.*  
(State or country) *Maryland*10 NAME OF FATHER *John Schen*11 BIRTHPLACE OF FATHER (city or town) *Germany*  
(State or country)12 MAIDEN NAME OF MOTHER *Margaret Speer*13 BIRTHPLACE OF MOTHER (city or town) *Balto.*  
(State or country) *Maryland*

14

Informant (Address) *John G. Klein Raskenburg Md.*

8 1922

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 26 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Aug 1*, 1921, to *Feb 26*, 1922.that I last saw her alive on *Feb. 23*, 1922.and that death occurred, on the date stated above, at *5:30* m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Stomach*  
(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Wm. C. Arvey* M. D.Feb 27, 1922 (Address) *839 S. Eglwood av*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*MOVAL Holy Redeemer Cemetery**March 1, 1922*

20 UNDERTAKER

ADDRESS

*Fredk. Lassafras Fullerton*

D 61787

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90

D 61787

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 235 South Eden

ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Frieda Mary Friedlander

(a) RESIDENCE No. 235 S. Eden

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos.

How long in U. S., if of foreign birth? 19 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Friedlander

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 61

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Philip Friedlander (Address) 235 S. Eden St.,

15 Filed 19 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1922

17 I HEREBY CERTIFY, That I attended deceased from February 25, 1922, to Feb. 28, 1922, that I last saw her alive on Feb. 27, 1922, and that death occurred, on the date stated above, at 7.15 A. m.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis and Myocardial Infarction

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Chronic Bronchitis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exams (Signed) Eugene Hooper M. D. 19 (Address) 403 Park Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Arthur Ross dals 2-28 1922 Jack Lewis, 141 E. Park

D 61788 HEALTH DEPARTMENT—CITY OF BALTIMORE: D 61788

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (NO.

Lombard &amp; Green

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Barbara Thomas -

(a) RESIDENCE. NO.

Sylkesville, Md.

ST.

WARD.

Sylkesville Md.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Richard Thomas -

6 DATE OF BIRTH (month, day, and year)

Autumn 1887

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

34

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework - 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Maryland -

10 NAME OF FATHER

Aaron White

11 BIRTHPLACE OF FATHER (city or town)

Md -

(State or country)

12 MAIDEN NAME OF MOTHER

Jesse Dowdy -

13 BIRTHPLACE OF MOTHER (city or town)

Virginia

(State or country)

14

Informant

University Hospital Records

(Address)

University Hosp. Bldg. Md.

15

281922

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

2-25-1922

17

I HEREBY CERTIFY, That I attended deceased from

2-22, 1922, to 2-25, 1922,

that I last saw her alive on 2-25, 1922,

and that death occurred, on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH\* was as follows:

Pregnant Peritonitis

(duration) yrs. mos. 4 da.

CONTRIBUTORY  
(Secondary)

(duration) yrs. 9 mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 2-22-22

Was there an autopsy?

What test confirmed diagnosis?

Regime

(Signed)

Morris Reu

M. D.

2-25, 1922 (Address)

University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn Cemetery

2/28 1922

20 UNDERTAKER

ADDRESS

Mrs Geo W Hooper 406 St. Canby

61789

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61789

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mount Hope Retrial* ST. *28* WARD)

## 2-FULL NAME

*Rev. Patrick J. Harkins*

## (a) RESIDENCE. NO.

*Mt Hope Retrial*ST. *28th* WARD.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

*Phila Philadelphia*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *0* yrs. *0* mos. *17* ds. How long in U. S., if of foreign birth? *0* yrs. *0* mos. *0* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Single*6 DATE OF BIRTH (month, day, and year) *About 1859*7 AGE Years *63* Months *0* Days *0* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Clergyman*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Religious Work.*

(c) Name of employer

9 BIRTHPLACE (city or town) *St. Clair* (State or country)10 NAME OF FATHER *Not Known (by us)*11 BIRTHPLACE OF FATHER (city or town) *Not Known* (State or country)12 MAIDEN NAME OF MOTHER *Not Known (by us)*13 BIRTHPLACE OF MOTHER (city or town) *Not Known* (State or country)

## 14

Informant (Address)

*Records of Mt Hope Retrial*

## 15

*Robert F. Harrison*

Burial Permit Clerk. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 25th* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *Feb 9th*, 19 *22*, to *Feb 25*, 19 *22*, that I last saw him alive on *Feb 24*, 19 *22*, and that death occurred, on the date stated above, at *11.10 P* m.

The CAUSE OF DEATH\* was as follows:

*Paralysis Post Arteriosclerosis of Cerebral Arteries -**abt (?)* (duration) *0* yrs. *1* mos. *0* ds.CONTRIBUTORY *mania Depression -*(Secondary) *abt (?)* (duration) *0* yrs. *1* mos. *0* ds.18 Where was disease contracted *Penna* if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *J. Frank J. Flannery*, M. D.*Feb 26th* 19 *22* (Address) *Mt Hope Retrial*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*St. Clair Penna**March 1st* 19 *22*

20 UNDERTAKER

*STEWART & MOWEN COMPANY*  
(WILLIAM F. WOODEN, Successor)

ADDRESS

*103 W. NORTH AVE*

8 1922



# CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Probably terminal  
cerebral hemorrhage*

D 61790

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703-W-Fayette-St.

ST.: 4 WARD)

2-FULL NAME Patience McClure Fakle

(a) RESIDENCE. No. 703-W-Fayette-St.

ST.: 4 WARD.

(resident)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 56 yrs. ? mos. ? ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Single

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

(single)

6 DATE OF BIRTH (month, day, and year) About-1866

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

About 56

?

?

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Hat-trimmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

Manf'g Hats.

(c) Name of employer

Townsend-Grace & Co.

9 BIRTHPLACE (city or town) (State or country)

Smithburg Maryland

10 NAME OF FATHER Charles Fakle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Smithburg Washington Co., Md.

12 MAIDEN NAME OF MOTHER (Miss) ? McClure

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Smithburg Md.

14

Informant Mrs. Emma W. Fanshaw (non-relative) (Address) 703-W-Fayette-St., City.

Robert P. Harrison,

Registrar

Burial Permit Clerk.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb-26-1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 23, 1922, to Feb. 25, 1922.

that I last saw him alive on Feb. 25, 1922.

and that death occurred, on the date stated above, at 7-a. m.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency-  
Auricular Fibrillation-  
General anasarca.

(duration) 20 yrs. ? mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. M. Gay, M. D.

, 19 (Address) 1107 St Paul St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Smithburg, Washington Co. Md. Mar-1-

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 22.

108 W. NORTH AVE.

8-8-1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61791

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1510 N. Mallwood ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. 1510 N. Mallwood ST.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

John Gungling

6 DATE OF BIRTH (month, day, and year) Dec 6 1858

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

62

2

20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home work

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Herkiah Gungling

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

L. M. Harbaugh

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

14

Informant

(Address)

Harry G. Gungling  
1510 N. Mallwood

ROBERT P. Harrison,

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/26/22

17

I HEREBY CERTIFY, That I attended deceased from

19

to 7/26/22

19

that I last saw him alive on 7/26/22

and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH was as follows:

Chronic Endocarditis

CONTRIBUTORY

(Secondary)

(duration)

yrs.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

(Address)

1429 W. Monument

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Uniontown Md

March 1922

20 UNDERTAKER

ADDRESS

H. M. Routson

2238 N. North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61792

61792

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Lambert &amp; Grace St. 15 WARD)

2-FULL NAME

Oliver Milton Helleskov

(a) RESIDENCE. NO.

4101 Jones Park Ave. St.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

25 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofMaud Segafosse Helleskov  
1852

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

70

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

Piano Factory

(c) Name of employer

E. H. M. Steff  
Carrace Co.9 BIRTHPLACE (city or town)  
(State or country)

Maryland

10 NAME OF FATHER

Wm. Helleskov

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Louisa Swigert

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant  
(Address)Mrs. Herbert L. Lacey  
503 Roush St. P. O. Box 100

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

2/26/22

17

I HEREBY CERTIFY, That I attended deceased from

Dec - 7 1921, to Feb 26 1922

that I last saw him alive on Feb 26 1922

and that death occurred, on the date stated above, at 10 25 p.m.

The CAUSE OF DEATH\* was as follows:

Concussion Abdomen

Indefinite

(duration)

CONTRIBUTORY

Secondary

(duration)

18 Where was disease contracted  
if not at place of death?

Not known

Did an operation precede death? Yes Date of

Dec 15/21

Was there an autopsy?

No

What test confirmed diagnosis

Clinical Findings

(Signed)

H. B. Jones

M. D.

2/26/22 Address

Carrace Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cemetery

March 1922

20 UNDERTAKER

ADDRESS

H. Maurice Roulton

223 N  
South Ave



D 61793

## HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH

61793

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 3022 Egleston Terrace)

ST. 13 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME REINA BLOOM

(Residence in Baltimore: No. 3022 Egleston Terrace)

St. 45 yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX female 4-COLOR OR RACE white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widow

6-DATE OF BIRTH Feb. 1, 1832 (Month) (Day) (Year)

7-AGE 90 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

## 8-OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

retired housewife

## 9-BIRTHPLACE (State or country)

Rumania

## 10-NAME OF FATHER

Lose Klawnsky

## 11-BIRTHPLACE OF FATHER (State or country)

Rumania

## 12-MAIDEN NAME OF MOTHER

Ellen (Klawnsky)

## 13-BIRTHPLACE OF MOTHER (State or country)

Rumania

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. L. Bloom (per. son)

(Address) 3310 Rochester Terrace

15.

Robert P. Harrison,

Filed

191

REGISTRAR

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH February 28, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1914, to Feb. 28, 1922.

that I saw her alive on Feb. 27, 1922.

and that death occurred, on the date stated above, at 6:10 a. m.

The CAUSE OF DEATH\* was as follows:

Diabetes Mellitus

(Duration) 8 yrs. mos. ds.

Contributory (SECONDARY)

Infirmitas of old age

(Duration) yrs. mos. ds.

(Signed), David J. Macdonald M. D.

Feb. 28, 1922 (Address) 3400 Egleston Terrace

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

## 19-PLACE OF BURIAL OR REMOVAL

Baltimore Hebrew Cem

## DATE OF BURIAL

2-28-1922

## 20-UNDERTAKER

Jack Lewis 1439 E. Baltimore

## ADDRESS

is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61794

## CERTIFICATE OF DEATH.

D 61794

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2312 E Hoffman ST., 8 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)  
Length of residence in city or town where death occurred

2312 E Hoffman ST.,

## WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female &amp; white

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Nov 17 1870

## 7 AGE

51 3

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

## 10 NAME OF FATHER

Thomas H Meares

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

## 12 MAIDEN NAME OF MOTHER

Martha Robinson

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

## 14

Informant  
(Address)Miss Mary D. L. Meares  
2312 E Hoffman St

## 15

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Feb 27 1922

## 17 I HEREBY CERTIFY, That I attended deceased from

Feb 21, 1922, to Feb 27, 1922.

that I last saw her alive on Feb 27, 1922.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Cerebral Haemorrhage

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

ADDRESS

Baltimore Kern & Mark 1922  
William Beck 5026 North Ave

Burial Permit Clerk

# HEALTH DEPARTMENT--CITY OF BALTIMORE

D 61795

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Volunteers of America Hospital*

REGISTERED NO.

CITY OF BALTIMORE: (No. *418 W. Lexington St.* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Chas. I. Black*

(a) RESIDENCE. No. *2413 E. North Ave.* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *1* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? *0* yrs. *0* mos. *0* ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of *Martha Black*  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) *9 = 1891*

7 AGE Years *31* Months *—* Days *—* If LESS than 1 day, hrs. *—* or min. *—*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Farmer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *out of work*

9 BIRTHPLACE (city or town) (State or country) *Maine*

10 NAME OF FATHER *C. P. Black*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Maine*

12 MAIDEN NAME OF MOTHER *Don't know*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Don't know*

14 Informant *John Burke*  
(Address) *1522 Eutaw Place*

15 *Robert P. Harrison*  
Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 27 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Feb. 13*, 1922, to *Feb. 27*, 1922,

that I last saw him alive on *Feb. 27*, 1922,

and that death occurred, on the date stated above, at *8:15 p.m.*

The CAUSE OF DEATH\* was as follows:

*Double Lobar Pneumonia*

(duration) yrs. *1* mos. *0* ds.

CONTRIBUTORY *Delirium Tremens - Em -*  
(Secondary) *pyemia - acute dilatation of*  
*Heart - Pneumonia* (duration) yrs. *0* mos. *0* ds.

18 Where was disease contracted if not at place of death? *2413 E. North Ave*

Did an operation precede death? *Yes* Date of *Feb. 25-22*

Was there an autopsy? *no*

What test confirmed diagnosis? *Paracentesis*

(Signed) *J. L. Payaswall* M. D.

, 19 (Address) *418 W. Lexington St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Grundy Cemetery* *3/1 1922*

20 UNDERTAKER ADDRESS

*William Cook* *601 E. W. St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

HEREBY CERTIFY That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

(duration) yrs. / mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



HEALTH DEPARTMENT—CITY OF BALTIMORE  
CERTIFICATE OF DEATH.

D 61797

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2-FULL NAME

*Curtis Platter*

(a) RESIDENCE, NO.

*907 Linden Ave.*

(Usual place of abode)  
Length of residence in city or town where death occurred

*unknown*

How long in U. S., if of foreign birth?

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*Colored*

5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Feb. 1920*

7 AGE

*2*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*?*

12 MAIDEN NAME OF MOTHER

*Virginia Platter*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*?*

14 Informant

(Address)

*Robert P. Harrison,*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb 26 - 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Feb. 7<sup>th</sup>*, 1922, to *Feb. 26<sup>th</sup>*, 1922, that I last saw him alive on *Feb. 26<sup>th</sup>*, 1922, and that death occurred, on the date stated above, at *9<sup>41</sup> P. M.*

The CAUSE OF DEATH\* was as follows:

*Thoracic Rickets*

CONTRIBUTORY (Secondary)

(duration) *6* yrs. *6* mos. *6* ds.

*Broncho pneumonia*

(duration) *1* yrs. *3* mos. *3* ds.

18 Where was disease contracted if not at place of death?

*907 Linden Ave.*

Did an operation precede death? *No* Date of

Was there an autopsy? *Yes*

What test confirmed diagnosis?

*Autopsy*

(Signed) *Horace G. Stewart*, M. D.

(Address) *Johns Hopkins Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Mt. Auburn Co.*

DATE OF BURIAL

*2/28 1922*

20 UNDERTAKER

*John B. Boyle*

ADDRESS

*102 E Mulberry*

*Feb 28 1922*

*Birthal Permit 125122*

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2-FULL NAME

MRS MIRIAM YOUNG

(a) RESIDENCE. NO.

Mukmanago

(Usual place of abode)

Length of residence in city or town where death occurred

ys.

mos.

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

(or) WIFE of

Dr. Laurel E. Young

6 DATE OF BIRTH (month, day, and year)

Feb. 21, 1867

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

55

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

N. Y.

10 NAME OF FATHER

John Barrow

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Mass.

12 MAIDEN NAME OF MOTHER

Miriam Evans

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

New York

14

Informant

(Address)

15

FEB 28 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 27, 1922

17 I HEREBY CERTIFY, That I attended deceased from

Jan. 29, 1922, to Feb. 27, 1922

That I last saw him alive on Feb. 27, 1922

and that death occurred, on the date stated above, at 10:15 P. M.

The CAUSE OF DEATH\* was as follows:

CHRONIC NEPHRITIS  
ART. SCLEROSIS - HYPERTENSION -  
MYOCARDIAL INSUFFICIENCY

(duration) 5 yrs. - mos. - ds.

CONTRIBUTORY (Secondary)

Ac. UREMIA

(duration) - yrs. - mos. - ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) John L. Dorsey, M. D.

19 (Address) J. H. H.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Waukegan, Wisconsin

DATE OF BURIAL

Feb. 28 1922

20 UNDERTAKER

John O. Mitchell

ADDRESS

1201 D. St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 61799

## CERTIFICATE OF DEATH.

33 D 61799

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital)ST.: 17 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Scott(a) RESIDENCE. NO. 412 Maryland AveST. 17 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

33

--

--

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)West River,  
Maryland

10 NAME OF FATHER

George Petus

PARENTS

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)West River,  
Maryland

12 MAIDEN NAME OF MOTHER

Lizzie Smith

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)West River,  
Maryland

14

Informant Hospital Records,  
(Address) Municipal Hospital.

15

Filed FEB 28 1922ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 19 22

17

I HEREBY CERTIFY, That I attended deceased from  
February 2, 19 22, to February 24, 19 22  
that I last saw h. alive on February 23, 19 22,  
and that death occurred, on the date stated above, at 5:45 A.M.

The CAUSE OF DEATH\* was as follows:

Multiple fistulae in duo-  
(possibly Tubercular)(duration) yrs. 3? mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
If not at place of death?HomeDid an operation precede death? no Date of —Was there an autopsy? no

What test confirmed diagnosis?

Clinical findings(Signed) L.H. Humber M. D.2/26/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

HOPKINS HOSPITALFEB 28 1922

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61800

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *41*)

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

10 yrs.

mos.

ds. How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

July 2, 1886

7 AGE

Years

Months

Days

35

5

14

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Serbia

10 NAME OF FATHER

Mike Sommaro

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Serbia

12 MAIDEN NAME OF MOTHER

Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Serbia

14

Informant (Address)

15

Filed

19

ROBERT R. KRAUTER

Registrar

FEB 28 1922

Bureau Permit Clerk,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 16, 1922

17 I HEREBY CERTIFY, That I attended deceased from

Feb 8, 1922 to Feb 16, 1922

that I last saw him alive on Feb. 16, 1922

and that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH\* was as follows:

Cellulitis of Left arm (abscess)

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Home

Did occupation precede death? Yes

Date of death Feb 10, 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John J. Sommaro, M.D.

Address Mercy Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

JOHNS HOPKINS HOSPITAL

DATE OF BURIAL

FEB 2, 1922

20 UNDERTAKER

Oconomowoc Health,



# CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Cause unknown.*

# HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D 61801

## CERTIFICATE OF DEATH.

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

D 61801  
1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)  
Length of residence in city or town where death occurred

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15

ST. 17 WARD

ST. WARD. (If nonresident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February-18-1922

17 I HEREBY CERTIFY, That I attended deceased from March-3, 1921, to February-18, 1922, that I last saw him alive on February-18, 1922, and that death occurred, on the date stated above, at 10:30 p. m.

The CAUSE OF DEATH\* was as follows:

Toxemia and Exhaustion

CONTRIBUTORY (duration) yrs. mos. ds. Pulmonary Tuberculosis (Secondary) (duration) yrs. 11 mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination of Sputum

(Signed) William B. Schwartz M. D.

2/19, 1921 (Address) Maryland Penitentiary.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

FEB 25 1922

FEB 28 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61802

## CERTIFICATE OF DEATH.

31

D 61802

## PLACE OF DEATH

CITY OF BALTIMORE (No. *815 Ashland ave* St. *10* WARD)

## REGISTERED No. C

## FULL NAME

*Anna Coleman*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *815 Ashland ave* , *on City ave*

St.: yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

1-SEX <i>Female</i>	4-COLOR OR RACE, <i>col.</i>	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word.) <i>Married</i>
6-DATE OF BIRTH, <i>Aug 1 1888</i> (Month) (Day) (Year)		
7-AGE, <i>44</i> yrs. .... mos. .... ds. If LESS than 1 day, ... hrs. or ... min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. .... (b) General nature of industry, business, or establishment in which employed (or employer). .... <i>Domestic</i>		
9-BIRTHPLACE, (State or Country), <i>Italy</i>		
PARENTS.	10-NAME OF FATHER, <i>Ely G. Gipsaw</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>Md.</i>	
	12-MAIDEN NAME OF MOTHER <i>Mary Gipsaw</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Md.</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) *William Coleman*  
(Address) *815 Ashland ave*

15-  
**FEB 28 1922** **ROBERT R. KRAUTER,**  
Burial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb 24 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
*Terminal Pulmonary Tuberculosis*  
(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) .....  
(Duration) .... yrs. .... mos. .... ds.

(Signed) *J. H. H. Insley* M. D.  
(Coroner)  
*2-28-22* 101.2 (Address) *48 S. St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

**FEB 28 1922**

**D 61803 HEALTH DEPARTMENT—CITY OF BALTIMORE**  
**CERTIFICATE OF DEATH.** **179 D 61803**

**1-PLACE OF DEATH**  
 CITY OF BALTIMORE: (No. 849 Hollins St ST. 18 WARD)  
**2-FULL NAME** Mary Praeger McCurley  
 (a) **RESIDENCE. NO.** 849 Hollins St. ST. 18 WARD.  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred 71 yrs. 10 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**REGISTERED NO.**  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

**PERSONAL AND STATISTICAL PARTICULARS**  
**3 SEX** Female **4 COLOR OR RACE** White **5 Single, Married, Widowed, or Divorced (write the word)** Widow  
**5a If married, widowed, or divorced HUSBAND of (or) WIFE of**  
**6 DATE OF BIRTH (month, day, and year)** Apr. 3, 1850  
**7 AGE** Years 71 Months 10 Days 24 If LESS than 1 day, hrs. or min.  
**8 OCCUPATION OF DECEASED**  
 (a) Trade, profession or particular kind of work None  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

**9 BIRTHPLACE (city or town) (State or country)** Baltimore  
**10 NAME OF FATHER** Harry Inefily  
**11 BIRTHPLACE OF FATHER (city or town) (State or country)** Heubaden Germany  
**12 MAIDEN NAME OF MOTHER** Marie Knapp  
**13 BIRTHPLACE OF MOTHER (city or town) (State or country)** Seelbach Germany

**14 Informant** Mrs. Burnett Gossch  
 (Address) 26 Somerset Rd.

**200187**  
**FEB 28 1922**  
**ROBERT R. KAUFER**  
 Registrar  
 Burial Permit Clerk

**MEDICAL CERTIFICATE OF DEATH**  
**16 DATE OF DEATH (month, day, and year)** Feb 27 1922  
**17 I HEREBY CERTIFY, That I attended deceased from** February 10, 1922, to February 27, 1922,  
 that I last saw her alive on February 27, 1922,  
 and that death occurred, on the date stated above, at 12:40 p.m.  
 The CAUSE OF DEATH\* was as follows:  
Arterio Sclerosis  
Chronic Nephritis  
 (duration) 5 yrs. 0 mos. 0 ds.  
**CONTRIBUTORY (Secondary)** Yperemia  
 (duration) 4 yrs. 0 mos. 0 ds.  
**18 Where was disease contracted if not at place of death?**  
 Did an operation precede death? No Date of —  
 Was there an autopsy? No  
 What test confirmed diagnosis? Physical  
 (Signed) Edw. J. Colgan M. D.  
 Address 247 22nd St. S. S. Fulton Ave  
 \*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

**19 PLACE OF BURIAL, CREMATION OR REMOVAL** Greenmount Cem **DATE OF BURIAL** 3/1 1922  
**20 UNDERTAKER** Geo. Smith 1000 Fayette St.



D 61804 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61804

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1703A. Munroe ST. 15 WARD)

2-FULL NAME

Isaac Kaufman

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

1703A. Munroe

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Kaufman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 45 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Cigar 117

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Born in Germany

10 NAME OF FATHER Moses Kaufman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Born in Germany

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Born in Germany

14 Informant F. Colaneri (Address) 1703A. Munroe St.

15 FEB 28 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1920 to Feb 27, 1922, that I last saw him alive on Feb 26, 1922, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis arteriosclerotic

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. H. M. D.

(Address) 12254 Columbia

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Balto Hebrew Cem 3/1/22

20 UNDERTAKER ADDRESS

J. Ahrens Co 1611 Madison

D 61805 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61805

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 924 Ches. St. 10 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 924 E Ches. St. yrs. 50 mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH,

Nov 17 1850

(Month)

(Day)

(Year)

7-AGE,

71 yrs

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Sexton 886

(b) General nature of industry, business, or establishment in which employed (or employer).

St. Johns Church

9-BIRTHPLACE,

(State or Country),

Connecticut

PARENTS.

10-NAME OF FATHER,

Geo. Kearney

11-BIRTHPLACE OF FATHER,

(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER,

Mary Shorten

13-BIRTHPLACE OF MOTHER,

(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Les. Kearney

(Address),

924 E Ches. St.

15-

FILED

FEB 28 1922

ROBERT N. KRAUTER,

Burial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Feb. 25, 1922

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry, find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Accident (Duration) yrs. mos. ds.

(Signed)

James M. Peniston M. D.

Feb. 26 1922 (Address) 700 E. Ches. St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral

Mar. 1, 1922

20-UNDERTAKER,

ADDRESS

H. L. Winfield 914 Greenback Ave

D 61806 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 Edgewale Road

ST.: 27<sup>th</sup> WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 606 Edgewale Road

St.: yrs. 4 mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male 4-COLOR OR RACE: White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH: Jan. 29, 1845 (Month) (Day) (Year)

7-AGE: 76 yrs. 11 mos. 7 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Retired (b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Smyrna Del.

10-NAME OF FATHER: Francis Wilds

11-BIRTHPLACE OF FATHER (State or Country): Smyrna Del.

12-MAIDEN NAME OF MOTHER: Mary Borough

13-BIRTHPLACE OF MOTHER (State or Country): Smyrna Del.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. H. W. Southerby

(Address) 606 Edgewale Road

FEB 28 1922

ROBERT R. KRAUTER,

Filed 191 Bural Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: Feb. 28, 1922 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct. 1921, to Feb. 28, 1922, that I saw him alive on Nov. 1921, and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH\* was as follows: Sudden Cerebral Arteriosclerosis, Cerebral Hemorrhage, probably.

CONTRIBUTORY (Secondary) Bright's Disease (Duration) yrs. 6 mos. ds.

(Signed) M. H. P. (Address) 422 Roland Ave. M. D. Feb. 28, 1922

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death: yrs. mos. ds. In the State: yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence: Smyrna Del.

19-PLACE OF BURIAL OR REMOVAL: Clayton Delaware DATE OF BURIAL: March 2, 1922

20-UNDERTAKER: John Spence, 1325 N. Caroline St. ADDRESS:

# HEALTH DEPARTMENT—CITY OF BALTIMORE CERTIFICATE OF DEATH.

D 61807

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1422 Battery Ave. ST. 24)

2-FULL NAME

(a) RESIDENCE. No. 1422 Battery

(Usual place of abode)  
Length of residence in city or town where death occurred

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced, name of HUSBAND or (or) WIFE of

Gordon Cordray

6 DATE OF BIRTH (month, day, and year)

Sept 12 - 1868

7 AGE

53

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

Thomas Barry

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Richmond Va

12 MAIDEN NAME OF MOTHER

Alma Kennedy

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Richmond Va

14 Informant (Address)

Gordon Cordray 1422 Battery Ave

15 FEB 28 1922

ROBERT H. KRAUTER Registrar

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD.

(If nonresident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1922

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw alive on

and that death occurred, on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH was as follows:

Coronary Atherosclerosis

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis? 1918

(Signed) J. E. Pomeroy M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park

DATE OF BURIAL

3/1/1922

20 UNDERTAKER

E. J. Tammings 460 Battery Ave



# CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc., of*..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Nonmalignant*

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61808

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3104 Fair Ave

ST.:

WARD)

2-FULL NAME Irma S. Francis

(a) RESIDENCE. No. 3104 Fair Ave

ST.,

WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan. 29-1903

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

19

-

28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto., Md.

10 NAME OF FATHER

Dixon Francis

11 BIRTHPLACE OF FATHER (city or town)

Balto., Md.

(State or country)

12 MAIDEN NAME OF MOTHER

Julia Dranbauer

13 BIRTHPLACE OF MOTHER (city or town)

Balto., Md.

(State or country)

14

Informant

(Address)

Julia Francis  
3104 Fair Ave

15

Filed

FEB 28 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 24<sup>th</sup> 1922, to Feb 27<sup>th</sup> 1922.

that I last saw her alive on Feb 27<sup>th</sup> 1922.

and that death occurred, on the date stated above, at 1:50 P. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY

(Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) W. H. Schwabach M. D.

, 19 (Address) 7345 Ellwood Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oaklawn

DATE OF BURIAL

Mar 2 1922

20 UNDERTAKER

J. J. J. J. J.

ADDRESS

1739 Eager

61809

## HEALTH DEPARTMENT-CITY OF BALTIMORE

## CERTIFICATE OF DEATH

D 61809

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

1413 Hull

Ann E Ferguson

1413 Hull

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (If write the word) Single

6-DATE OF BIRTH Feb 11, 1922 (Month) (Day) (Year)

7-AGE 30 yrs. 16 mos. 16 ds. If LESS than 1 day, hrs. or min.?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

## 9 BIRTHPLACE (State or country)

Balto Md

## 10 NAME OF FATHER

Wm J Ferguson

## 11 BIRTHPLACE OF FATHER (State or country)

Ireland

## 12 MAIDEN NAME OF MOTHER

Bridget O'Hara

## 13 BIRTHPLACE OF MOTHER (State or country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bridget Ferguson

(Address) 1413 Hull

15-

FEB 28 1922

ROBERT R. KRAUTER,

Burial Permit Clerk,

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Feb. 27, 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1922, to Feb. 27, 1922

that I saw him alive on Feb 26, 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Mitral Regurgitation  
acute dilatation  
(Duration) yrs. mos. ds.

## Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

Hoota Stevens

M. D.

2/27, 1922

(Address)

2878 Varford Rd

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Cathedral Cem.

## DATE OF BURIAL

Mar. 1, 1922

## 20 UNDERTAKER

Margaret G. Flynn

## ADDRESS

422 Light St.

is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61810

D 61810

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 N. Carey

ST. 18 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie S. Laupheimer

(a) RESIDENCE. NO. 123 N. Carey

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 10 mos. 28 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced (write the word)

Female

White

Widow

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Simon Laupheimer

6 DATE OF BIRTH (month, day, and year) March 28, 1873

7 AGE

Years

Months

Days

If LESS than  
1 day, .... hrs.  
or .... min.

48

10

28

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Sales - lady

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(Shoes)

(c) Name of employer

Stewart &amp; Co.

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore

Maryland

10 NAME OF FATHER

Patrick McLaughlin

PARENTS

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Do not know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Do not know

14

Informant  
(Address)

Mrs. Earl Kennedy

14 N. Calhoun Street

15

FEB 28 1922

ROBERT R. KRAUTER  
Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1922

17

HEREBY CERTIFY, That I attended deceased from  
Feb 21, 1922, to Feb 26, 1922,

that I last saw her alive on Feb 26, 1922,

and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH\* was as follows:

Edema of brain

(duration) yrs. mos. 2 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. S. Jones, M. D.

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

3/1, 1922

20 UNDERTAKER

ADDRESS

Henry W. Hears &amp; Son 805 N. Calvert



# CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*I find that Mrs Nellie  
Langheimer's death was  
due to arterio-sclerosis  
of the fall had nothing  
to do with her death.*

*James M. Toulon  
No hemorrhage. (Coroner)*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61811

## CERTIFICATE OF DEATH.

129 D 61811  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 Druid Hill Ave ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 917 Druid Hill Ave St.; 25 yrs.,    mos.    ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, widow  
(Write the word.)6-DATE OF BIRTH, Jan 1 1978  
(Month) (Day) (Year)7-AGE, 44 yrs.    mos.    ds. IF LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, Domestic  
(b) General nature of industry, business, or establishment in which employed (or employer), 0709-BIRTHPLACE, (State or Country), Charles County MdPARENTS.  
10-NAME OF FATHER, John N. Jennifer  
11-BIRTHPLACE OF FATHER (State or Country), Charles County Md  
12-MAIDEN NAME OF MOTHER, Lollie Banks  
13-BIRTHPLACE OF MOTHER (State or Country), Prince George Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), John N. Jennifer  
(Address), Hughesville Charles CountyFEB 28 1922  
FiledROBERT H. KRAUTER,  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 29, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Feb 4th 1922, to Feb 27 1922, that I saw him alive on Feb 27th 1922, and that death occurred, on the date stated above, at 10 p. m. The CAUSE OF DEATH\* was as follows:  
Chronic Nephritis(Duration) 2 yrs. 6 mos.    ds.  
CONTRIBUTORY (Secondary) Uremia  
(Duration)    yrs.    mos.    ds.(Signed) W. G. Smith M. D.  
Feb 28, 1922 (Address) 1354 W. Belknap St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hughesville Charles Co DATE OF BURIAL, March 2, 192220-UNDERTAKER, Edward W. Pye ADDRESS 903 Edmondson Ave

61812

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61812

## CERTIFICATE OF DEATH

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. *3000 Hospital* ST. *3* WARD)FULL NAME *Hanislawa Cierskies.*(Residence in Baltimore: No. *626 S Bond* St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*Male*

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Mar.*

6-DATE OF BIRTH,

*Oct.**15, 1916*

7-AGE,

*5* yrs. *4* mos. *12* ds.

If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*None*

9-BIRTHPLACE,

(State or Country), *Mo.*10-NAME OF FATHER, *Julian Cierskies*

11-BIRTHPLACE OF FATHER

(State or Country), *Poland*

12-MAIDEN NAME OF MOTHER

*Rozalia Korytkowska*

13-BIRTHPLACE OF MOTHER

(State or Country), *Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Rozalia Cierskies*(Address) *626 S Bond St.*

FEB 28 1922

ROBERT R. KRAUTER,

Filed

191

Burial Permit

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Feb.**27**1922*

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy, or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Struck by street car.*

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed) *R. R. Krauter*

(Coroner)

7-28, 191 (Address) *7-28, 191*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,

*Holy Rosary.*

DATE OF BURIAL,

*2/1*, 1922

20-UNDERTAKER,

*William Galkowski*

ADDRESS

*118 Eastern*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61813

D 61813

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mt Hope Retreat* ST. *28th* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs Anna Mary Sullivan*(a) RESIDENCE. No. *Mt Hope Retreat* ST. *28th* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 7 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*5a If married, widowed, or divorced HUSBAND of *Mr Sullivan* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *Oct. 4, 1865*7 AGE Years *56* Months *5* Days *0* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Maryland*10 NAME OF FATHER *Thomas J. Harden*11 BIRTHPLACE OF FATHER (city or town) *Howard Co* (State or country) *Md*12 MAIDEN NAME OF MOTHER *Anne Jackson*13 BIRTHPLACE OF MOTHER (city or town) *Howard Co* (State or country) *Md*14 Informant *Records of Mt Hope Retreat* (Address) *Mt Hope Md.*15 *FEB 28 1922* ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 25* 192217 I HEREBY CERTIFY, That I attended deceased from *Sept 29th* 1921, to *Feb 25* 1922.that I last saw him alive on *Feb 25* 1922.and that death occurred, on the date stated above, at *11 30 a. m.*

The CAUSE OF DEATH\* was as follows:

*General Neuritis (with Paralysis as a sequela)*

(duration) 0 yrs. 7 mos. 0 ds.

CONTRIBUTORY *Depressive Psychosis* (Secondary)

(duration) 0 yrs. 7 mos. 0 ds.

18 Where was disease contracted *Baltimore Md* if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Frank J. Flannery* M. D.19 (Address) *Mt Hope Retreat*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*New Cathedral Cemetery* 3-2-1922

20 UNDERTAKER

*William Cook*

ADDRESS

*502 E North*



# CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Resident of Balto.*  
*No hemorrhage.*

D 61814

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61814

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD) <sup>131</sup>

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Flemming

(a) RESIDENCE. NO. Unknown ST. \_\_\_\_\_ WARD. \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1867  
7 AGE Years Months Days If LESS than 1 day, hrs. or min. 54 -- --

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,  
(State or country) Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown  
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)

14 Informant Hospital Records,  
(Address) Municipal Hospital.

15 MAR 1 - 1922 ROBERT R. KRAUTER  
Burial Permit Clerk.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 19 22

17 I HEREBY CERTIFY, That I attended deceased from February 26 19 22 to February 27 19 22.  
that I last saw him alive on February 27 19 22.  
and that death occurred, on the date stated above, at 4:00 A.M.  
The CAUSE OF DEATH\* was as follows:

Pneumonia  
(duration) yrs. 2 mos. ds.

CONTRIBUTORY Chemia  
(Secondary) (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Negative  
(Signed) Clifford M. Mearns M. D.

2/27/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL

Baltimore Cemetery March 1 1922  
20 UNDERTAKER ADDRESS

George - J. Ruth 1735 Hayford

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61815

## CERTIFICATE OF DEATH.

31 D 61815

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 E Preston ST., 10 WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 1207 E Preston ST., WARD(Usual place of abode) Length of residence in city or town where death occurred 54 yrs. - mos. - ds. How long in U. S. if of foreign birth? 8 yrs. - mos. - ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of Annie M. Holzer (or) WIFE of6 DATE OF BIRTH (month, day, and year) Nov. 3<sup>rd</sup> 18617 AGE Years 60 Months 3 Days 25 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) Washington (State or country) D.C.10 NAME OF FATHER Frederick Holzer11 BIRTHPLACE OF FATHER (city or town) Berlin (State or country)12 MAIDEN NAME OF MOTHER Margaret Helten13 BIRTHPLACE OF MOTHER (city or town) Berlin (State or country)14 Informant Annie M. Holzer (Address) 1207 E Preston15 MAR 1 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 28<sup>th</sup> 192217 I HEREBY CERTIFY, That I attended deceased from Feb. 1<sup>st</sup> 1922 to Feb. 28<sup>th</sup> 1922, that I last saw him alive on Feb. 28<sup>th</sup> 1922, and that death occurred, on the date stated above, at 8<sup>15</sup> A.M.  
The CAUSE OF DEATH\* was as follows:  
Pulmonary tuberculosis(duration) yrs. ? mos. ? ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?Did an operation precede death? no Date of noneWas there an autopsy? noWhat test confirmed diagnosis? microscope(Signed) J. Duquesne, M. D.(Address) 1206 E. Preston St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-  
MOVAL First Baptist Evangelical Church

DATE OF BURIAL

March 2<sup>nd</sup> 1922

ADDRESS

1301 E. Jay St.

20 UNDERTAKER

Henry Howard Lee

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61816

## CERTIFICATE OF DEATH.

129 D 61816

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1426 Park Ave

ST. 14 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Dixon Burns

(a) RESIDENCE. NO. 1426 Park Ave  
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 11 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lindley H. Burns

6 DATE OF BIRTH (month, day, and year) March 11, 1842

7 AGE Years 79 Months 11 Days 17 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home At home pos

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Baltimore, Ind  
(State or country)

10 NAME OF FATHER William Brown

11 BIRTHPLACE OF FATHER (city or town) Ireland  
(State or country)

12 MAIDEN NAME OF MOTHER Mary A. Caughy

13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country)14 Informant L. Hegeland Burns  
(Address) 1426 Park Ave15 MAR 1 - 1922 ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 28, 1922

17 I HEREBY CERTIFY, That I attended deceased from February 10, 1922, to February 28, 1922.

that I last saw him alive on Feb 27, 1922.

and that death occurred, on the date stated above, at 6:15 a.m.

The CAUSE OF DEATH\* was as follows:

Uraemia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) 2 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 2

Was there an autopsy? No

What test confirmed diagnosis? Pus from gall bladder + Pus in air

(Signed) Frank O' Donovan, M. D.

Feb 28, 1922 (Address) 5 E. Read St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cem

3-2-1922

20 UNDERTAKER

ADDRESS

Henry W. Jones &amp; Son Co

1426 Park Ave



# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61817

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 834 N. Lexington St. ST.: 18 WARD)

2-FULL NAME Annie M. Herman

(a) RESIDENCE. NO. 834 N. Lexington St. ST.: 18 WARD.

(Usual place of abode) Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 2, 1891

7 AGE Years 80 Months 3 Days 24 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife  
(b) General nature of industry, business, or establishment in which employed (or employer) ooo  
(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

10 NAME OF FATHER Geo Schneider

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Dr. Knoll

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Geo Herman (Address) 834 N. Lexington

15 **MAR 1 - 1922** **ROBERT R. KRAUTER,**  
Burial Permit Clerk.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26<sup>th</sup> 1922

17 I HEREBY CERTIFY, That I attended deceased from July 16<sup>th</sup>, 1922, to July 26<sup>th</sup>, 1922, that I last saw him alive on July 26<sup>th</sup>, 1922, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH\* was as follows:

Senility

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt. J. Murray, M. D.

2-28, 1922 Address 5 No. N. Vermont Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Redeemer Mar 2 1922

20 UNDERTAKER ADDRESS

John F. Fields 1201 N. Lombard



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61819

## CERTIFICATE OF DEATH.

D 61819

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 S. Fremont Ave ST. 18 WARD)

REGISTERED NO. C

## 2-FULL NAME

(Residence in Baltimore: No. 14 S. Fremont Ave St.; 32 yrs., — mos., — da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

SEX.

DATE OF BIRTH,

7-AGE,

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.....
- (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,  
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

(Address),

15-

MAR 1 - 1922

ROBERT H. KRAUTER,

Burial Permit Clerk,  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I attended deceased from Feb 21, 1922, to Feb 28, 1922, that I saw her alive on Feb 28, 1922, and that death occurred, on the date stated above, at 2 A.M.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)

(Signed),

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. .... mos. .... da. In the State..... yrs. .... mos. .... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

61820

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *819 S. Becker Ave* ST.,

WARD

## 2-FULL NAME

*Theresa J. Ebert*

(a) RESIDENCE NO.

*819 S. Becker Ave* ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female White*

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Mar 19<sup>th</sup> 1908*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.*13**11**8*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*School attendant*

(b) General nature of industry, business, or establishment in which employed (or employer)

*DOO*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Balto. Md.*

10 NAME OF FATHER

*Michael A. J. Ebert*

11 BIRTHPLACE OF FATHER (city or town)

*Balto. Md.*

(State or country)

12 MAIDEN NAME OF MOTHER

*Margt. Goeffert*

13 BIRTHPLACE OF MOTHER (city or town)

*Berulany*

(State or country)

14

Informant  
(Address)*Michael A. J. Ebert  
819 S. Becker Ave*

15

MAR 1 - 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit 61820

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 27<sup>th</sup> 1922*

17

I HEREBY CERTIFY, That I attended deceased from  
*Feb*, 1921, to *Feb 27*, 1922.that I last saw him alive on *Feb 27*, 1922.and that death occurred, on the date stated above, at *11 45 a.m.*

The CAUSE OF DEATH\* was as follows:

*Brach. Pneumonia*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?*Place of death*

Did an operation precede death?

*no*

Date of

*none*

Was there an autopsy?

*no*

What test confirmed diagnosis?

*129*

(Signed)

*W. Z. Burke*

M. D.

, 19

(Address)

*3042 Hudson St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Sacred Heart Cem**Mar 2<sup>nd</sup> 1922*

20 UNDERTAKER

ADDRESS

*Filly & Zieh**403 S. W. 45th*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

61821

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *17 W. Ostera* ST. *23* WARD)

## 2. FULL NAME

*Samuel J. Lambert*

(a) RESIDENCE NO.

*19 W. Ostera*

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

*Life* yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male White Married*

6a If married, widowed, or divorced, HUSBAND of (or) WIFE of

*Catherine Jane Lambert*

6 DATE OF BIRTH (month, day, and year)

*June 21 1840*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*81*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Caulker 086*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Retired*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balto. Md*

10 NAME OF FATHER

*Jos. Lambert*

11 BIRTHPLACE OF FATHER (city or town)

*Md*

(State or country)

12 MAIDEN NAME OF MOTHER

*Cher Wera*

13 BIRTHPLACE OF MOTHER (city or town)

*Not known*

(State or country)

14

Informant (Address)

*Catherine J. Lambert 19 W. Ostera St*

15 MAR 1 - 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 28 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 28* 19 *22* to *Feb 27* 19 *22* that I last saw him alive on *Feb 27* 19 *22* and that death occurred, on the date stated above, at *7:15* A. M.

The CAUSE OF DEATH\* was as follows:

*Broncho pneumonia from history of neural work*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Bronchitis*

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

*At home*

Did an operation precede death?

*No*

Date of

Was there an autopsy?

*No*

What test confirmed diagnosis?

(Signed) *Robt. R. Krauter*, M. D.

Mar 1 1922 (Address)

*1318 S. Charles St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Mount Olivet Cemetery**Mar 2, 1922**John F. Denny**715 Light*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61822

## CERTIFICATE OF DEATH.

90 D 61822

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 N. Robinson ST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. 427 N. Robinson ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. - mos. - ds. How long in U. S., if of foreign birth? 32 yrs. - mos. - ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND or

(or) WIFE of

John Hoeres

6 DATE OF BIRTH (month, day, and year)

Feb 19-63

7 AGE

59

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

9

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

John Ebeling

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

John Hoeres  
427 N. Robinson St.

15

Filed

MAR 1 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 28 1922

17

I HEREBY CERTIFY, That I attended deceased from

Dec 1 1921, to, Feb 27 1922,

that I last saw him alive on Feb 26 1922,

and that death occurred, on the date stated above, at 6:05 A. M.

The CAUSE OF DEATH\* was as follows:

Endocarditis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

Terminal Pneumonia

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

R. Krauter

M. D.

2210 22 (Address)

2439 Mc Eldeny

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cedar Hill

3/3 1922

20 UNDERTAKER

Philip Herwig

ADDRESS 2016

Orleans

# CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Chronic endocarditis.*  
*Bronchus Pneumonia.*  
*No further history.*

D 61823

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61823

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1112 N. Patterson Pl. Ave. ST. 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Frank C. Chlhart(a) RESIDENCE. NO. 1112 N. Pat. Pl. Ave. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 10 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of

Margaret Chlhart6 DATE OF BIRTH (month, day, and year) Apr 26 - 587 AGE Years 63 Months 10 Days 2 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Lineman

(b) General nature of industry, business, or establishment in which employed (or employer)

Sparrows Pt.

(c) Name of employer

Bethlehem Steel Co

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

John Chlhart

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

PARENTS

14 Informant (Address)

Margaret Chlhart  
1112 N. Pat. Pl. Ave

15

MAR 1 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1922

17 I HEREBY CERTIFY That I attended deceased from

Jan. 4, 1922 to Feb. 25, 1922  
that I last saw him alive on Feb. 25, 1922and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH was as follows:

mitral stenosis regurgitation(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) J. E. Burkholder M. D.228 1922 (Address) 1531 E. Northside

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

McBarnes

DATE OF BURIAL

3/2 1922

20 UNDERTAKER

Philip Herwig

ADDRESS

2016Oleans



61824 HEALTH DEPARTMENT-CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3616 Fairview Ave. Forest Park WARD)

## 2-FULL NAME

Sarah Kennedy Gambel

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE. NO.

3616 Fairview Ave

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 10 mos. 26 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1, 1858

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

63

10

26

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Retired

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

School Teacher

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore

Maryland

10 NAME OF FATHER Thomas B. Gambel

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Baltimore

Maryland

12 MAIDEN NAME OF MOTHER Julia Aler

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Reisterstown

Maryland

14

Informant  
(Address)

Fortunato R. Schiaffino

3616 Fairview Ave.

15

Filed

19

ROBERT R. KRAUTER

Registrar

MAR 1 - 1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Dec. 20, 1921, to Feb. 27, 1922

that I last saw her alive on February 27, 1922,

and that death occurred, on the date stated above, at 1:20 P.M.

The CAUSE OF DEATH\* was as follows:

Pulmonary oedema +  
Pleurisy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY  
(Secondary)Chronic Auricular Deafness  
(Continued from Pneumonia)

(duration) yrs. 2 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical examination

(Signed) Maurice E. Shann, M.D.

Feb. 28, 1922 (Address) 3300 W. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Green Mount Cemetery

DATE OF BURIAL

3/1, 1922

20 UNDERTAKER

Henry W. Mears &amp; Son 805 N. Calvert

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61825

## CERTIFICATE OF DEATH.

164  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D 61825

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 756 Dolphin St. ST.; 17 WARD)

## 2-FULL NAME

Isabelle C. Murphy(a) RESIDENCE. NO. 756 Dolphin St. ST., \_\_\_\_\_ WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) July-18467 AGE Years 75 Months \_\_\_\_\_ Days \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nurse

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) (State or country) New York City10 NAME OF FATHER John Murphy11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada12 MAIDEN NAME OF MOTHER Catharine Brady13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York State14 Informant Miss Isabelle Sweigler (Address) 756 Dolphin St.15 File MAR 1-1922 ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 192217 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1922, to Feb 28, 1922, that I last saw h. alive on Feb 26, 1922, and that death occurred, on the date stated above, at 7 P. m. The CAUSE OF DEATH\* was as follows:Senility(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted if not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

(Signed) Robt. J. Murray, M. D.3-1, 1922 (Address) 510 M. Trunovs av

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cedar Hill

DATE OF BURIAL

March 2 1922

20 UNDERTAKER

Robert S. Little

ADDRESS

2200 Edmondson

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61826

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Park Hill Place and  
Green Spring Ave.

CITY OF BALTIMORE: (No.

ST. 13 WARD)

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

2-FULL NAME

Lester L. Kingsbury

Park Hill Place

(a) RESIDENCE No. and Green Spring Ave.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Mildred C. Kingsbury

6 DATE OF BIRTH (month, day, and year) Oct. 25<sup>th</sup> 1860

7 AGE

61

Years

Months

4

Days

3

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work Electrical Engineer(b) General nature of industry,  
business, or establishment in  
which employed (or employer) Chief Electrical  
Inspector

(c) Name of employer Baltimore City.

9 BIRTHPLACE (city or town)  
(State or country)Townhill  
Pa

10 NAME OF FATHER David Woodward Kingsbury

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Huntington  
Pa

12 MAIDEN NAME OF MOTHER Henrietta Andrews

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Asbury  
Pa

14 Informant Mrs. Mildred C. Kingsbury

Address Park Hill Place &amp; Green Spring Ave.

15

MAR 1 - 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28<sup>th</sup> 1922

17

I HEREBY CERTIFY, That I attended deceased from  
February 24<sup>th</sup>, 1922, to February 28<sup>th</sup>, 1922,  
that I last saw him alive on February 27<sup>th</sup>, 1922,  
and that death occurred, on the date stated above, at 1.10 A. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of esophagus -  
Carcinoma of stomach - fundus  
Metastasis of lungs - kidneys - liver.

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted  
if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) G. W. Bishop M. D.

Feb. 28, 1922 Address 501 Sheridan Ave

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

London Park Cemetery Nov. 3<sup>rd</sup> 1922

20 UNDERTAKER

ADDRESS

Joseph B. Cook 1003 N. Baltimore

61827

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3734 Gough*)2-FULL NAME *Frieda Heiser*(a) RESIDENCE. No. *3734 Gough*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. *76* WARD)

ST. WARD.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*John L. Wisner*

6 DATE OF BIRTH (month, day, and year)

*Feb. 20 / 1890*

7 AGE

*32*

Years

Months

Days

If LESS than 1 day, hrs. or min.

*8*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balto.*

10 NAME OF FATHER

*Andrew Lustle*

11 BIRTHPLACE OF FATHER (city or town)

*Balto.*

(State or country)

12 MAIDEN NAME OF MOTHER

*Barbara*

13 BIRTHPLACE OF MOTHER (city or town)

*Balto*

(State or country)

14

Informant (Address)

*John L. Wisner 3734 Gough St.*

15

MAR 1 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 28* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb. 27*, 19 *22*, to *Feb. 27*, 19 *22*.that I last saw ~~her~~ alive on *Feb. 27*, 19 *22*.and that death occurred, on the date stated above, at *12:25 a.m.*

The CAUSE OF DEATH\* was as follows:

*Partial Abstruction of Esophagus (Due to ingestion of some disinfectant)*(duration) yrs. *3* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation preceed death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *H. D. Alley*, M. D.Address *2504 20th St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL

DATE OF BURIAL

*Oak Lawn Cem. Mar. 2, 1922*

20 UNDERTAKER

ADDRESS

*Philip's Herwig 2016 Calver St.*



# CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Form laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

History from *Ward A. Municipal*  
ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Woman took cresol intentionally  
Taken to St. Joseph's Hosp. &  
given first aid. Dissatisfied  
with treatment then went home.  
Later went to Municipal Hosp.  
where X Rays showed complete  
stricture of esophagus due to  
swallowing cresol.*

D 61828

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61828

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1010 S. Fremont Ave. St. 21 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....Magnolia Hammond, (C).....

16 -- 11 -- 22.

(Residence in Baltimore: No. 1010 S. Fremont Ave. St.; yrs., mos., ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female. 4-COLOR OR RACE, Colored. 5-Single, Single. Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, March 4, 1905. (Month) (Day) (Year)

7-AGE, 16 yrs. 11 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None. (b) General nature of industry, business, or establishment in which employed (or employer), 800

9-BIRTHPLACE, (State or Country), Baltimore Md.

10-NAME OF FATHER, John W. Hammond, (C)

11-BIRTHPLACE OF FATHER, (State or Country), Calvert Co. Md.

12-MAIDEN NAME OF MOTHER, Maggie Lee, (C).

13-BIRTHPLACE OF MOTHER, (State or Country), St. Michaels. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Maggie Hammond, (mother).

(Address), 1010 S. Fremont Ave.

15-MAR 1 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 26, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to her death on the day stated above. (Inquest, autopsy or inquiry.)

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis.

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D.

(Coroner), Feb. 27, 1922. (Address) 1017 S. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mt Auburn Cemetery Mar. 1, 1922

20-UNDERTAKER, ADDRESS

Mrs. George H. Hooper, 406 Conway St.

Per. Alex Nelson

D 61829

## HEALTH DEPARTMENT-CITY OF BALTIMORE

## CERTIFICATE OF DEATH

61829

PLACE OF DEATH

CITY OF BALTIMORE (No. 159-100)

REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

(Residence in Baltimore: No. 920 Gough Ave)

St. yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

COLOR OR RACE

White

SINGLE, MARRIED, WIDOWED, OR DIVORCED

Single

DATE OF BIRTH

Feb

16, 1922

AGE

yrs.

mos.

12

ds.

If LESS than

1 day, hrs.

or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

6 Full

BIRTHPLACE

(State or country)

Little Orleans Ind

NAME OF FATHER

Archibald Shaper

BIRTHPLACE OF FATHER

(State or country)

Baltimore Md

MAIDEN NAME OF MOTHER

Edith Souverain

BIRTHPLACE OF MOTHER

(State or country)

Maryland

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Archibald Shaper

(Address)

Little Orleans Maryland

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Feb 28

1922

191

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

, 191, to, 191,

that I saw h alive on , 191,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

This baby died on home coming from Little Orleans to Baltimore to consult a child specialist. From what information I could get from mother I gathered that cause of death was congenital tubercular infection.

(Duration) yrs. mos. ds.

Contributory Born Feb. 16 - 22

(SECONDARY) Died. " 28 - 22

(Duration) yrs. mos. ds.

(Signed) H. E. Prentiss

M. D.

Feb. 28 - 1922 (Address) 634 Gough Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wood Ridge Cemetery

3/1, 1912

20. UNDERTAKER

ADDRESS

William Cook

5026 North

MAR 1 - 1922

ROBERT R. KRAUTER,

Filed

191

Burial Permit

REGISTRAR

is very important. See instructions on back of certificate.

D 61830

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61830

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

JOHN HOPKINS HOSPITAL

ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs Emma Schneider.*

(a) RESIDENCE. NO. *3426 Mt. Pleasant ave* ST.,

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Female*

*White*

*married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *don't know 1882*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*40 40*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

*137*

(c) Name of employer

9 BIRTHPLACE (city or town) *Maryland* (State or country)

10 NAME OF FATHER *John McEnroe*

11 BIRTHPLACE OF FATHER (city or town) *Maryland* (State or country)

12 MAIDEN NAME OF MOTHER *Catherine Whalen*

13 BIRTHPLACE OF MOTHER (city or town) *Maryland* (State or country)

14

Informant (Address)

15 *1-1922* Robert P. Harrison,

Registrar

Burial Permit Clerk:

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 25* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 20* - 19*22*, to *Feb 25* - 19*22*, that I last saw her alive on *Feb 25* - 19*22*, and that death occurred, on the date stated above, at *5:00 P.* m. The CAUSE OF DEATH\* was as follows:

*Adenoma of Thyroid (Substernal)*

CONTRIBUTORY (Secondary)

(duration) *2* yrs. *2* mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *Yes* Date of *Feb 27/1922*

Was there an autopsy? *No*

What test confirmed diagnosis? *Operation*

(Signed) *Paul Holman*, M. D.

, 19 (Address) *Johns Hopkins Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Cathedral City* *March 3 1922*

20 UNDERTAKER

ADDRESS

*George F. Ruth 1735 Hayford Ave.*



HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61831

D 61831

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *University Hospital*

CITY OF BALTIMORE: (No. *Lombard & Jones*)

ST. *22* WARD

2-FULL NAME *Wm H. Roberts*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. *606 Columbia Ave.* ST. \_\_\_\_\_ WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 ☒ Single Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1872.*

7 AGE Years *50* Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Printer 863*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto. Md.* (State or country)

10 NAME OF FATHER *William H. Roberts*

11 BIRTHPLACE OF FATHER (city or town) *Balto. Md.* (State or country)

12 MAIDEN NAME OF MOTHER *Elizabeth Smallen*

13 BIRTHPLACE OF MOTHER (city or town) *Balto* (State or country)

14 Informant *Thomas D. Roberts* (Address) *120 W. 109th St. New York N.Y.*

15 Filed *1922* Robert P. Harrison, Registrar

Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2/28 1922*

17 I HEREBY CERTIFY, That I attended deceased from *2/22*, 1922, to *2/28*, 1922, that I last saw him alive on *2/28*, 1922, and that death occurred, on the date stated above, at *8 9* a.m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary T.B.*

(duration) *3* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted *Home* If not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *physic signs* (Signed) *W. H. Jones*, M. D.

Address *Univ Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Baltimore County 3/2 1922*

20 UNDERTAKER ADDRESS

*George J. Smith 5000 St.*

D 61832

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61832

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2424 Liberty Heights AVE. ST. 15 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME A. Olive Hess

(a) RESIDENCE. NO. 2424 Liberty Heights ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 1 mos. 16 ds. How long in U. S. if of foreign birth? — yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Stephen C. Hess

6 DATE OF BIRTH (month, day, and year) Jan. 11, 1885

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	37	1	16	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland

10 NAME OF FATHER William J. Mills

11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Kate Wills

13 BIRTHPLACE OF MOTHER (city or town) Charles Co.  
(State or country) Maryland14 Informant Stephen C. Hess  
(Address) 2424 Liberty Heights Ave15 Filed 1-1922 Robert P. Harrison,  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28, 1922

17 I HEREBY CERTIFY, That I attended deceased from  
Feb. 17, 1922, to Feb. 28, 1922,  
that I last saw her alive on Feb. 28, 1922,  
and that death occurred, on the date stated above, at 12:45 p. m.  
The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual signs

(Signed) W. H. Smith, M. D.

, 19 (Address) 109 W. Lee St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral Cemetery

3/2 1922

20 UNDERTAKER

ADDRESS

Henry W. Mears &amp; Son 805 N. Calvert

Burial Permit Clerk

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61833

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *525 W Lexington St.* ST. *17* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *408 N. Pearl St.* St.; yrs. *7* mos. *14* da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

## 6-DATE OF BIRTH

*Aug. 14<sup>th</sup>, 1911.*  
(Month) (Day) (Year)

## 7-AGE

yrs. *7* mos. *14* da.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*At home*

## 9-BIRTHPLACE, (State or Country),

*Ind.*

## 10-NAME OF FATHER,

*Rocco Lima.*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Italy*

## 12-MAIDEN NAME OF MOTHER

*Josephine Alasario*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Balto. Md.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

*Josephine Lima*  
*408 N. Pearl St.*

## 15-

Filed

191

Registrar.

1922

Burial Permit Clerk.]

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Feb 28, 1922.*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan 17<sup>th</sup> 1922*, to *Feb 28 1922*, that I saw her alive on *Feb 28 1922*, and that death occurred, on the date stated above, at *md*

The CAUSE OF DEATH\* was as follows:

*Malnutrition*(Duration) yrs. *2* mos. *0* da.

## CONTRIBUTORY (Secondary)

*Bronchitis*(Signed) *M. L. Brown* M. D.3-1-1922 (Address) *2609 Allendale Rd. Balto.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

*West Catholic Cem Co.* *2/28/22*

## 20-UNDERTAKER ADDRESS

*John H. Hays & Sons* *1318 Light St.*

*No gastro enteritis. Malnutrition due to bad feeding.*

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

*lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

*Abortion, Cellulitis, Childbirth, Convulsions, Hamorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.*

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (if induced), whether death is directly or indirectly due to the same.



D 61834

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3806 Chatham Rd., ST. 15 WARD)

2-FULL NAME

Annie Whipp Elmer

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 3804 Chatham Rd.St.; yrs. 17 mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)married

6-DATE OF BIRTH,

July 31, 1881  
(Month) (Day) (Year)

7-AGE,

40 yrs. 6 mos. 27 ds.

IF LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).Housewife9-BIRTHPLACE,  
(State or Country).Philadelphia Pa.

10-NAME OF FATHER,

John T. Whipp11-BIRTHPLACE OF FATHER  
(State or Country).England

12-MAIDEN NAME OF MOTHER

Annie E. M. Feeters13-BIRTHPLACE OF MOTHER  
(State or Country).Penn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Reverend W. Elmer

(Address)

3804 Chatham Rd.

15-

Robert P. Harrison,

Filed

191

-1922

Burial Permit Clerk.

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Feb. 28, 1922  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest  
(Inquest, au-opsy and that said deceased came to death  
(topsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

suicide by gas inhalation

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Harrison M. D.

(Coroner.)

March 1, 1922 (Address) 3804 Chatham Rd.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Lorraine CemeteryMar 2-22

20-UNDERTAKER

ADDRESS

Betham & Co.1437 N. E. St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61835

## CERTIFICATE OF DEATH.

D 61835

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 7 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Pickens Robbins.(a) RESIDENCE. NO. Lenora, N.C. ST.: Lenora N.C.

(Usual place of abode)

WARD

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary Ann Penley.6 DATE OF BIRTH (month, day, and year) Oct 13 18537 AGE Years Months Days If LESS than 1 day, hrs. or min. 68

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) N.C. (State or country)10 NAME OF FATHER James Robbins.11 BIRTHPLACE OF FATHER (city or town) N.C. (State or country)12 MAIDEN NAME OF MOTHER Mary Ann Penley.13 BIRTHPLACE OF MOTHER (city or town) N.C. (State or country)14 Informant JOHNS HOPKINS HOSPITAL (Address)15 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 192217 I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1921, to March 1, 1922.that I last saw him alive on March 1, 1922.and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH\* was as follows:

Benign Hypertrophy Prostate.  
Pyelonephritis, bilateral of long.  
Uræmia.(duration) 1 yrs. 4 mos. ds.CONTRIBUTORY Pulmonary hæmorrhage. (Secondary)(duration) 2 yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct. 13, 1921Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Charles Schaffer Beck, M. D.19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Lenora N.C.

DATE OF BURIAL

March 1 1922

20 UNDERTAKER

Joseph Ahrens

ADDRESS

2211 Bury



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61837

D 61837

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3323 Stafford Lane ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 3323 Stafford Lane St. Life yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

SEX. <u>Male</u>	4-COLOR OR RACE, <u>White</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) <u>Married</u>
6-DATE OF BIRTH. <u>Oct</u> <u>3</u> , <u>1898</u> (Month) (Day) (Year)		
7-AGE, <u>43</u> yrs. <u>4</u> mos. <u>25</u> ds.	IF LESS than 1 day. ...hrs. or...min.	
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).		
<u>Carpenter</u> <u>015</u>		
9-BIRTHPLACE, (State or Country), <u>Maryland</u>		

PARENTS.	10-NAME OF FATHER, <u>Unknown</u>
	11-BIRTHPLACE OF FATHER (State or Country), <u>Unknown</u>
	12-MAIDEN NAME OF MOTHER <u>Unknown</u>
	13-BIRTHPLACE OF MOTHER (State or Country), <u>Unknown</u>

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James C. Whitworth  
(Address) 3323 Stafford Lane

15-

Filed....., 191... ROBERT R. KRAUTER, Registrar.

MAR 2-1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 28, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Jan 16 1922, to Feb 28 1922, that I saw him alive on Feb 28 1922, and that death occurred, on the date stated above, at 11-15 P. m.  
The CAUSE OF DEATH\* was as follows:Pulmonary Tuberculosis  
(Duration) Over 2 mos. ds.CONTRIBUTORY (Secondary) None  
(Duration) Over 2 yrs. mos. ds.(Signed) Wm C. Able M. D.  
March 1 1922 (Address) 1223 W. Fayette St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Int. Clivestown DATE OF BURIAL, March 3 192220-UNDERTAKER Chenoweth & Son ADDRESS Chestnut



# HEALTH DEPARTMENT—CITY OF BALTIMORE

57 D 61838

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *13*)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)  
Length of residence in city or town where death occurred

Yrs.

Mos.

ds. How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14 Informant  
(Address)

15

MAR 2 - 1922 ROBERT R. KRAUTER, Registrar  
Burdal Permit Clerk.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from

March 1, 1922, to March 2, 1922.

that I last saw her alive on March 2, 1922, at 2:20 a.m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH was as follows:

Diabetes

CONTRIBUTORY (duration) yrs. mos. ds.

(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory findings Physical signs

(Signed) John P. Brown, M. D.

19 (Address) Mercy Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

16 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn March 4 1922

20 UNDERTAKER

Chenoweth & Son Chestnut

D 61839

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2016 Keyser ST.: 8 WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE C. 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of

6 DATE OF BIRTH (month, day, and year) 2/28/1922

7 AGE Years 10 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

10 NAME OF FATHER Robert Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charlottesville, Va.

12 MAIDEN NAME OF MOTHER Elvira Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charlottesville, Va.

14 Informant (Address) 2016 Keyser St. ROBERT R. KRAUTER, Registrar

15 Filed 19 MAR 2 - 1922 Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/28/1922

17 I HEREBY CERTIFY, That I attended deceased from 2/2/22 to 2/28/22, that I last saw her alive on 2/27/22, and that death occurred, on the date stated above, at 12:30 p. m.

The CAUSE OF DEATH\* was as follows:

Coronary of the heart and probably of the arteries, atherosclerosis etc. (duration) yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary) (duration) yrs. 1 mos. 13 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

Signed) Elmer F. Boyle, M. D.

Address) 1414 N. Caroline St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Drake Branch Va March 3 1922

20 UNDERTAKER ADDRESS 1925-

Mrs Robert A Elliott Ashland

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST.: WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

How long in U. S., if of foreign birth?

WARD.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

19

MAR 2 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Nov. 4<sup>th</sup>, 1921, to March 1<sup>st</sup>, 1922,that I last saw him alive on March 1<sup>st</sup>, 1922,

and that death occurred, on the date stated above, at 12:00 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray and Tuba Test

(Signed) T. B. Gray, M. D.

, 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laural Ave

March 2, 1922

20 UNDERTAKER

Mrs Robert A Elliott

ADDRESS 1725

Ashland Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61841

## CERTIFICATE OF DEATH.

D 61841

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No.

1127 Park Ave -

ST. 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

James Walton

(Residence in Baltimore No.

1127 Park Ave

St. 25 yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

Male

## 4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

## 6-DATE OF BIRTH,

..... Feb 19 1922 ..... 1 .....  
(Month) (Day) (Year)

## 7-AGE,

3-8

yrs. mos. ds.

If LESS than 1 day,

....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....Labor 140  
Labor

## 9-BIRTHPLACE, (State or Country),

live in Balt 25 years  
N C

## 10-NAME OF FATHER,

Jack Walton

## 11-BIRTHPLACE OF FATHER (State or Country),

N C

## 12-MAIDEN NAME OF MOTHER

Sarah Wright

## 13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

Mildred Talley

(Address).....

805-Atlantic St -

## 15-

Filed

MAR 2 - 1922

ROBERT R. KRAUTER

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

..... Feb 28 1922 .....  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from  
Feb 19 1922, to Feb 27 1922,  
that I saw him alive on Feb 27 1922,

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

..... (Duration)..... yrs..... mos..... ds.  
CONTRIBUTORY..... Exhaustion.....  
(Secondary)..... (Duration)..... yrs..... mos..... ds.  
(Signed)..... H. P. Hughes, M. D.  
2/28, 1922 (Address)..... 637 Moyer St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Mt Zion Ln

## DATE OF BURIAL,

March 1, 1922

## 20-UNDERTAKER

Mrs Robert A. Elliott

## ADDRESS,

1725 Ashland Ave



61842

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 D 61842

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (Municipal Tuberculosis Hospital) WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Iula Redd

(a) RESIDENCE. NO. 2047 Keyser st.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Moses Redd

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) live in Balt 3 years  
(State or country) Virginia

10 NAME OF FATHER John Wilson

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Lelia Powlkes

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Virginia14 Informant Hospital Records  
(Address) H.T.H.15 Filed MAR 2 - 1922 ROBERT R. KRAUTER  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28, 1922

17 I HEREBY CERTIFY, That I attended deceased from  
Feb. 27, 1922, to Feb. 28, 1922,  
that I last saw her alive on Feb. 27, 1922,  
and that death occurred, on the date stated above, at 12.45 a.m.  
The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY Tuberculous peritonitis  
(Secondary)

(duration) yrs. 3 mos. ds.

18 Where was disease contracted  
If not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) Francis J. P. Williams, M.D.

2-28-22 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Laural Cemetery

## DATE OF BURIAL

March 3, 1922

## 20 UNDERTAKER

Mrs Robert A Elliott

## ADDRESS

1725- Ashland Ave

# HEALTH DEPARTMENT—CITY OF BALTIMORE

61843

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. *JOHNS HOPKINS HOSPITAL* ST.; *5* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Irvin Jones*

(a) RESIDENCE, NO. *409 Somers* ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *unknown* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Male*

*Colored*

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Single*

6 DATE OF BIRTH (month, day, and year)

*June 28<sup>th</sup> 1909*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*12*

*June*

*28*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Child*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Maryland*

10 NAME OF FATHER

*James Riegle*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Md.*

12 MAIDEN NAME OF MOTHER

*Lena Jones*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Md.*

14

Informant (Address)

15

Filed

MAR 2 - 1922

Burial Permit

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb. 27<sup>th</sup> 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb. 24<sup>th</sup> 1922* to *Feb. 27<sup>th</sup> 1922*

that I last saw him alive on *Feb. 27<sup>th</sup> 1922*

and that death occurred, on the date stated above, at *5:20 a.m.*

The CAUSE OF DEATH\* was as follows:

*Lobar pneumonia*

(duration) yrs. mos. *6* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

*Home*

If not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *None*

(Signed) *Francis K. Dineen*, M. D.

19 Address *Johns Hopkins Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Laird Cemetery*

*March 2, 1922*

20 UNDERTAKER

*Mrs Robert A. Elliot*

ADDRESS

*1728*

*Baltimore*

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO

2-FULL NAME

(a) RESIDENCE. NO. (Usual place of abode)

Length of residence in city or town where death occurred

ST. 10 WARD

WARD.

(If nonresident give city or town and State)

How long in U. S. If of foreign birth?

ys. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

Filed

19

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Feb. 25<sup>th</sup> 1922, to Feb. 28<sup>th</sup> 1922,

that I last saw him alive on Feb. 28<sup>th</sup> 1922,

and that death occurred, on the date stated above, at 12:10 P.M.

The CAUSE OF DEATH\* was as follows:

Myocardial insufficiency

(duration) yrs. 2 mos. ds.

CONTRIBUTORY

(Secondary)

Aortic insufficiency

Systolic (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis K. Dicunade M. D.

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 61845

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *4* WARD) D 61845

2-FULL NAME *Rich Ross*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. *Beltsville, Md.* ST. *1* WARD.

(Usual place of abode)

ST. *1* WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *1* mos. *24* ds. How long in U. S., if of foreign birth? *13* yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND or (or) WIFE of *-*

6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *31* *-* *-*

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer.* 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Austria*

10 NAME OF FATHER *Rich Ross*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Austria*

12 MAIDEN NAME OF MOTHER *Viola (unknown)*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Austria*

14 Informant *Adolph Ross* (Address) *Beltsville, Md.*

15 *MAR 2 - 1922* ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 28* 19*22*

17 I HEREBY CERTIFY, That I attended deceased from *Jan. 4,* 19*22*, to *Feb. 28,* 19*22*. That I last saw him alive on *Feb. 28,* 19*22*.

and that death occurred, on the date stated above, at *5.20 P. m.*

The CAUSE OF DEATH\* was as follows:

*Acute and mitral regurgitation*  
*Chronic myocarditis.*

*unknown* (duration) yrs. mos. ds.

CONTRIBUTORY *Acute endocarditis* (Secondary)

(duration) yrs. mos. *14* ds.

18 Where was disease contracted if not at place of death? *unknown.*

Did an operation precede death? *No.* Date of

Was there an autopsy? *No.*

What text confirmed diagnosis? *Physica.*

(Signed) *J. Willis Guyton*, M. D.

19 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Vol. Gross Cemetery & A. L. Howard 2<sup>d</sup>* 19*22*

20 UNDERTAKER

*Geo Leimbach & Son*

ADDRESS

*647 W. Pratt St.*





## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61847

CERTIFICATE OF DEATH

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 Wilson ally ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 209 Wilson ally St.; yrs. mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MAR 2 - 1922

ROBERT R. KRAUTER  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from 2/28 1922, to 3/1 1922, that I saw her alive on 3/1 1922, and that death occurred, on the date stated above, at 7 P. m. The CAUSE OF DEATH\* was as follows:  
Alzheimer's  
(Duration) yrs. mos. da.  
CONTRIBUTORY (Secondary) Prognathism  
(Duration) yrs. mos. da.  
(Signed) W. B. Johnson M. D.  
3/2 1922 (Address) 1901 E. 1st St.  
\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

61848

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

3/1/22

7 AGE

Years

Months

Days

If LESS than  
1 day, 4 hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Inf. ood

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore, Md.

10 NAME OF FATHER

James Alvar

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Lea Matilda Payton

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Maryland

14

Informant  
(Address)James A. Blueford  
727 N. Fremont

15

Filed

19

ROBERT R. KRAUTER

Bureau Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/1/22

17

I HEREBY CERTIFY, That I attended deceased from  
3/1/22 - 1235 AM 19 to 3/1/22 4.35 AM 19

that I last saw him alive on 3/1/22

and that death occurred, on the date stated above, at 4.35 AM

The CAUSE OF DEATH\* was as follows:

Premature birth  
wt. 3# 4oz

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Harper M. D.

19 (Address) St. Agnes Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Mary's Hospital

3/2/22

20 UNDERTAKER

ADDRESS

William Cook

602 E. North Ave.

MAR 2 - 1922

D 61849 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Brichner

(a) RESIDENCE. No. 418 Gilmore St.

ST. 19 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos.

ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) 1843

7 AGE Years Months Days If LESS than 1 day. hrs. or min. 78 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Herman Brichner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fannie Bishop

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records, (Address) Municipal Hospital.

15 MAR 2 - 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 19 22

17 I HEREBY CERTIFY, That I attended deceased from February 25, 19 22, to February 27, 19 22. that I last saw h er alive on February 27, 19 22. and that death occurred, on the date stated above, at 9 P.M. m.

The CAUSE OF DEATH\* was as follows:

Pneumo pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Clyde McNeill M. D.

2/28/22 Address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park

DATE OF BURIAL

3/3/22

UNDERTAKER

William Cook

ADDRESS

502 E North



D 61850

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61850

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. ...)

2-FULL NAME

(Residence in Baltimore: No. ...)

Registered No. C. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-Single, Married, Widowed, or Divorced, (Write the word)

6-DATE OF BIRTH,

7-AGE,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

MAR 2 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk,

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY That I took charge of the remains described above, held an inquest, autopsy or inquiry.

Thereon and from the evidence obtained by said inquest, autopsy or inquiry, I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

CONTRIBUTORY (Secondary)

(Signed)

State the Disease Causing Death, or, in deaths from violent Cause, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER,

ADDRESS

D 61851

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61851

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1108 Sarah Ann* ST.: *18* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Edna Cooper*(a) RESIDENCE. NO. *1108 Sarah Ann* ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

*Life* yrs. mos. ds.(If nonresident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*col*

5 Single, Married, Widowed, or Divorced (write the word)

*single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Apr. 11 1902*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*19*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Domestic 070*

(b) General nature of industry, business, or establishment in which employed (or employer)

*house-work*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balto, Md*

10 NAME OF FATHER

*Edwin Cooper*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Md.*

12 MAIDEN NAME OF MOTHER

*Addie Johnson*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Md.*

14

Informant (Address)

*Ada Cooper 1108 Sarah Ann St.*

15

File

*MAR 2 - 1922*

ROBERT R. KRAUTER Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Mar 1 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Jan 26*, 1922, to *July 28*, 1922, that I last saw her alive on *July 28*, 1922, at *1 A.* m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

*Exhaustion*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*

What test confirmed diagnosis?

*Examination of organs*

(Signed)

*Wm. W. Way M. D.*

(Address)

*1006 Admonson*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Anselm**Mar 3 1922*

20 UNDERTAKER

ADDRESS *114 St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61852

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Laurel and Greene

ST.

WARD)

2-FULL NAME

William S. Murphy

(a) RESIDENCE. NO.

1921 Harlem

ST.

CARE WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

61 yrs.

-- mos.

-- ds.

How long in U. S., if of foreign birth?

-- yrs.

-- mos.

-- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Margaret Murphy.

6 DATE OF BIRTH (month, day, and year)

Mar. 25, 1860

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

61

11

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Police officer 061

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

John Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Kathryn Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Hospital Records

15

MAR 2-1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/1

1922

17

I HEREBY CERTIFY, That I attended deceased from

2/20/

1922, to

3/1

1922.

that I last saw him alive on

3/1/

1922.

and that death occurred, on the date stated above, at

9:05 p.m.

The CAUSE OF DEATH\* was as follows:

Acute Cardiac dilatation super-imposed upon C. H. Myocarditis

(duration)

yrs.

10 minutes

CONTRIBUTORY (Secondary)

Hypertrophied heart

(duration)

yrs.

mos. ds.

18 Where was disease contracted

if not at place of death?

Not known

Did an operation precede death?

Yes

Date of

2/24/22

Was there an autopsy?

Yes

What test confirmed diagnosis?

Chemical findings

(Signed)

Cyrus J. Hovine

M. D.

, 19

(Address)

University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

3/4,

1922

20 UNDERTAKER

ADDRESS

Henry W. Mears &amp; Son 805 N. Calvert

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61853

## CERTIFICATE OF DEATH.

Registered No. C.....

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1122 William St. St. 244 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Mary T. Imhoff.

(Residence in Baltimore: No. 1122 William St. St. yrs. mos. 20 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 4-COLOR OR RACE, 5-Single, Married, Widowed, or Divorced, (Write the word.)  
Female. White. Single.6-DATE OF BIRTH.  
February 9th, 1922. 1.  
(Month) (Day) (Year)7-AGE, If LESS than 1 day,  
mos. 20 ds. hrs. or min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. None.  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,  
(State or Country). Baltimore, Md.PARENTS.  
10-NAME OF FATHER, William Imhoff.  
11-BIRTHPLACE OF FATHER, (State or Country), Baltimore, Md.  
12-MAIDEN NAME OF MOTHER, Rose Boeh.  
13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Imhoff, (mother).

(Address) 1122 William St.

15-  
MAR 2 - 1922 ROBERT R. KRAUTER,  
Burial Permit Clerk Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,  
March 1st, 1922. 192.  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to her death on the day stated above.  
(Inquest, autopsy or Inquiry.)  
The CAUSE OF DEATH\* was as follows:Mitral Insufficiency.  
Congenital.

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)  
(Duration) yrs. mos. ds.  
(Signed) E. B. Harle M. D.  
(Coroner.)

March 1, 1922 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Holy Cross a.c. 3-2 1922

20-UNDERTAKER, ADDRESS

E. B. Harle 115 E. West St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61854

D 61854

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2317 E. Oliver* ST.; *8* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *2317 E. Oliver* St.; *53* yrs., *53* mos., *53* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Female*

## 4-COLOR OR RACE,

*White*

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

*Married*

## 6-DATE OF BIRTH,

*February 27<sup>th</sup>, 1845*  
(Month) (Day) (Year)

## 7-AGE,

*77*

If LESS than 1 day,

... hrs. or ... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Housewife - 131*

## 9-BIRTHPLACE,

(State or Country),

*Ireland*

## 10-NAME OF FATHER,

*Andrew Torrans*

## 11-BIRTHPLACE OF FATHER

(State or Country),

*Ireland*

## 12-MAIDEN NAME OF MOTHER

*Ann Gaurley*

## 13-BIRTHPLACE OF MOTHER

(State or Country),

*Ireland*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Johnston*(Address) *2317 E. Oliver St.*

## 15-

MAR 2 - 1922

ROBERT R. KRAUTER,

Filed

191

Burial Permit Clerk, Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*February 27, 1922*  
(Month) (Day) (Year)

## 17-I HEREBY CERTIFY, That I attended deceased from

*Feb 5<sup>th</sup> 1922, to Feb 27 1922,*that I saw her alive on *Feb 27<sup>th</sup> 1922,*and that death occurred, on the date stated above, at *53* m.

The CAUSE OF DEATH\* was as follows:

*Biliary Calculi*(Duration) *22* yrs. *22* mos. *22* ds.

## CONTRIBUTORY (Secondary)

*Old age*(Duration) *22* yrs. *22* mos. *22* ds.(Signed) *J. W. Keown**Feb 28, 1922* (Address) *1938 Linden Ave.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *53* yrs. *53* mos. *53* ds. In the State *53* yrs. *53* mos. *53* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Cedar Hill Cemetery**Mar 2, 1922*

## 20-UNDERTAKER

## ADDRESS

*Margaret L. Flynn**1422 Light St.*

D 61855 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-D 61855

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

JOHNS HOPKINS HOSPITAL ST. 1

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John D. Walker

(a) RESIDENCE. No.

2705 Fair Ave. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

WIFE of

Mary Walker

6 DATE OF BIRTH (month, day, and year)

Feb 5<sup>th</sup> 1868

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

63 (?)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Ironworker 079

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

John Walker

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Anne?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant

(Address)

15

Filed

MAR 2 - 1922

ROBERT A. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 14 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 20<sup>th</sup> 1922, to March 14<sup>th</sup> 1922

that I last saw him alive on March 12<sup>th</sup> 1922

and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH\* was as follows:

Anaemia perniciosa

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

if not at place of death? 2705 Fair Ave.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray

(Signed) E. Gordon Adams, M. D.

, 19 (Address) Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

North Cathedral Cem

3-4 1922

20 UNDERTAKER

J. G. Moran

ADDRESS 300

E. B. Becton

61856

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61856

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2345 Euton Place ST., 13 WARD)

2-FULL NAME Mrs. Lena Hoffmann Clarke.

(a) RESIDENCE NO. 2345 Euton Place.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Clarke

6 DATE OF BIRTH (month, day, and year) Feb 2/1849

7 AGE Years 73 Months - Days 27 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lissa, Germany (State or country)

10 NAME OF FATHER George Hoffman

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Carrie Heinig

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Emma Clarke (Address) 2345 Euton Place

15 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1922

17 I HEREBY CERTIFY, That I attended deceased from February 24, 1922, to March 1, 1922, that I last saw her alive on March 1, 1922, and that death occurred, on the date stated above, at 8:25 P.M.

The CAUSE OF DEATH\* was as follows:

Chronic nephritis.  
Arterial hypertension.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles F. Preston, M. D.

19 (Address) 1417 Euton Place

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL

BALTO HELEN

3/3 1922

20 UNDERTAKER Louis Soudheim

ADDRESS 1100 W. Royal

MAR 2 - 1922

D 61857

HEALTH DEPARTMENT-CITY OF BALTIMORE

23 D 61857

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Hebrew Hospital

ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME

Isadore Litinsky

(a) RESIDENCE. NO.

915 Chancery Ave

ST.

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred

How long in U. S. If of foreign birth

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 18 1904

7 AGE

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Barrel Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Morris Litinsky

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Benkova

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Every Casalofsky

14 Informant (Address)

Morris Litinsky 915 Chancery Ave

MAR 2 - 1922

ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3-2 1922

17 I HEREBY CERTIFY, That I attended deceased from 2-27 1922 to 3-2 1922

that I last saw him alive on 3-2 1922 and that death occurred, on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH\* was as follows:

Epidemic Encephalitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

20 Zinberg Hebrew Hospital M. D.

3/2, 1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL

Hebrew Cemetery

DATE OF BURIAL

3/2 1922

ADDRESS

20 UNDERTAKER

Jack Lewis 1439 E. Baltimore



# HEALTH DEPARTMENT—CITY OF BALTIMORE

61858

## CERTIFICATE OF DEATH.

113 D 61858

### 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 4715 Park Heights Ave. ST. 27 WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

Harwood Jack DeCalap

(a) RESIDENCE. NO. 4715 Park Heights Ave. ST. (Usual place of abode)

### WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. 8 ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 19 22 7 AGE Years Months Days If LESS than 1 day, hrs. or min. 5

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town, State or country) Baltimore Md

10 NAME OF FATHER Samuel Joeels

11 BIRTHPLACE OF FATHER (city or town, State or country) London Eng

12 MAIDEN NAME OF MOTHER Gertrude Klop

13 BIRTHPLACE OF MOTHER (city or town, State or country) Baltimore

14 Informant Jack Lewis (Address) 1439 E 13th St

15 FEB 2 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 19 22

17 I HEREBY CERTIFY, That I attended deceased from Feb 26 19 22, to Feb 2 19 22, that I last saw him alive on Feb 2 19 22, and that death occurred, on the date stated above, at 3 A m. The CAUSE OF DEATH\* was as follows:

Convulsions

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Charles J. Mills, M. D.

, 19 (Address) 2 N. Belvidere Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

### 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Nehruv Nash Road

### DATE OF BURIAL

3/2 19 22

### 20 UNDERTAKER

Jack Lewis 1439 E 13th St

# HEALTH DEPARTMENT—CITY OF BALTIMORE

**D 61859** CERTIFICATE OF DEATH.

31 **D 61859**

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO Municipal Tuberculosis Hospital **22** WARD)

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlie Johnson

(a) RESIDENCE. NO. 531 Burgundy Alley ST. \_\_\_\_\_ WARD. \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred Unknown mos. \_\_\_\_\_ ds. \_\_\_\_\_ How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not recorded

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If LESS than 1 day, hrs. \_\_\_\_\_ or min. \_\_\_\_\_

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman **086**

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

10 NAME OF FATHER Benjamin Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Laura Bodie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records (Address) M.T.H.

15 File **MAR 2 - 1922** ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 5 1922 to Feb. 28 1922.  
that I last saw him alive on Feb. 28 1922.

and that death occurred, on the date stated above, at 1.45 p. m.  
The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) yrs. 7 mos. \_\_\_\_\_ ds. \_\_\_\_\_

CONTRIBUTORY (Secondary)

(duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of \_\_\_\_\_

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) Francis L. DeBrylles, M.D.

**8-28-22** (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL DATE OF BURIAL \_\_\_\_\_

20-UNDERTAKER Commissioner Health,

ADDRESS **MAR 2 - 1922**

W. M. H. WOODALL

D 61860

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## PLACE OF DEATH

CITY OF BALTIMORE (No. 1349 Whatecoat St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## FULL NAME

(Residence in Baltimore: No. 1349 Whatecoat St. St.; yrs., 6 mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE,

Colored

## 5-SINGLE,

MARRIED, Single  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

Oct

1931

(Month)

(Day)

(Year)

## 7-AGE,

7 yrs. 7 mos. ds.

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,  
(State or Country).

Norfolk Va

## 10-NAME OF FATHER,

John P. Pailin

11-BIRTHPLACE OF FATHER  
(State or Country).

Norfolk Va

## 12-MAIDEN NAME OF MOTHER

Alice Cooper

13-BIRTHPLACE OF MOTHER  
(State or Country).

Norfolk Va

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Pailin

(Address) 1349 Whatecoat St.

## 15-

MAR 2 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

March 1, 1922  
(Month) (Day) (Year)

## 17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

## (Signed)

J. D. Hennessy, M. D.  
(Coroner)

March 1, 1922 (Address) 4802 Edmondson Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Norfolk Va

## 19-PLACE OF BURIAL OR REMOVAL,

McEuburn

## DATE OF BURIAL,

3/5, 1922

## 20-UNDERTAKER

Sam. J. Dunsley 57 W. Biddle

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61861

## CERTIFICATE OF DEATH.

D 61861  
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *814 N. Bond*)

ST.: *7*

WARD)

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

2-FULL NAME

*Mary F. Bowley*

(a) RESIDENCE. NO.

*814 N Bond*

ST.,

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*F*

4 COLOR OR RACE

*Col*5 Single, Married, Widowed,  
or Divorced (write the word)*Widow*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Sept 10 - 1879*

7 AGE

*42*

Years

Months

*5*

Days

*19*

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Landress*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore*

10 NAME OF FATHER

*Unknown*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Unknown*

12 MAIDEN NAME OF MOTHER

*Alice Byas*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Baltimore*

14

Informant  
(Address)*1001 Byas  
814 N Bond*

15

MAR 2 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 1 1922*

17 I HEREBY CERTIFY, That I attended deceased from

*Sept 2 1922 to March 1, 1922*that I last saw him alive on *Feb 28 1922*and that death occurred, on the date stated above, at *12 PM*

The CAUSE OF DEATH\* was as follows:

*Chronic Bright's Disease*CONTRIBUTORY  
(Secondary)

(duration)

yrs. *5* mos. *1* ds.

(duration)

yrs. *1* mos. *1* ds.18 Where was disease contracted  
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

*W. Clyde Barnes, M. D.*

3-1-22

(Address) *221 8th Prall*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Laurel*

20 UNDERTAKER

*John W Henderson*

DATE OF BURIAL

*March 19 22*ADDRESS *1823**1 monument*



# HEALTH DEPARTMENT-CITY OF BALTIMORE

## CERTIFICATE OF DEATH

61862

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2731) *Dillon*

2-FULL NAME *Frances Mary Strelczyk*

(a) RESIDENCE. No. 2731 *Dillon*

(Usual place of abode)  
Length of residence in city or town where death occurred *Life* yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*white*

5 Single, Married, Widowed, or Divorced (write the word)

*single*

5a If married, widowed, or divorced  
HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 5 1921*

7 AGE

Years

*9*

*27*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

*none*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore*

10 NAME OF FATHER

*Martin Strelczyk*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Poland*

12 MAIDEN NAME OF MOTHER

*Mary Jwanic*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Poland*

14 Informant

(Address)

*Martin Strelczyk*  
*2731 Dillon*

15 Filed

*MAR 2 - 1922*

*ROBERT A. KRISTEN*

Burial Permit Clerk

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST.:

WARD)

*(Schulz)*

ST.:

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 1 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Feb. 27 1922* to *March 1 1922*

that I last saw him alive on *March 1 1922*

and that death occurred, on the date stated above, at *130 P.M.*

The CAUSE OF DEATH\* was as follows:

*Broncho-Pneumonia*

CONTRIBUTORY (Secondary) *acute Bronchitis* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*no*

Did an operation precede death?

*no*

Was there an autopsy?

What test confirmed diagnosis?

*W. M. C. Avey, M. D.*  
*Edg. O. Edwood, Jr.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*St Stanislaus*

DATE OF BURIAL

*March 3 1922*

20 UNDERTAKER

*John M. Weber*

*1803 Bank*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female white

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

MAR 2 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 61864

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61864

## CERTIFICATE OF DEATH

161-002

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 Shields alley St. 17 WARD)

### 2-FULL NAME

Baby Bryn

### (a) RESIDENCE. NO.

912 Shields al

(Usual place of abode)  
Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### WARD.

(If nonresident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

#### 3 SEX

Male

#### 4 COLOR OR RACE

Black

#### 5 Single, Married, Widowed, or Divorced (write the word)

Infant

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

#### 6 DATE OF BIRTH (month, day, and year)

Feb 15 1922

#### 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

13

#### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

11

(c) Name of employer

11

#### 9 BIRTHPLACE (city or town) (State or country)

Baltimore  
Maryland

#### 10 NAME OF FATHER

George Owens

#### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

#### 12 MAIDEN NAME OF MOTHER

Elise Edna Bryn

#### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

#### 14 Informant (Address)

Elise Edna Bryn, (mother)  
912 Shields alley

#### 15 Filed

Robert P. Harrison,

Registrar

2-1922

Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

#### 16 DATE OF DEATH (month, day, and year)

Feb 28 1922

#### 17 HEREBY CERTIFY, That I attended deceased from

Feb 15 1922, to Feb 28 1922,

that I last saw him alive on Feb 27 1922,

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH\* was as follows:

Intracranial Hemorrhage

(duration)

yrs.

mos.

13 ds.

#### CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

Prolonged labor

#### 18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Morris Rice  
University Hospital

(Address)

19

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

#### 19 PLACE OF BURIAL, CREMATION OR REMOVAL

St Peters

#### DATE OF BURIAL

Mar 2 1922

#### 20 UNDERTAKER

Edward Ruggold 463 Carey

D 61865

HEALTH DEPARTMENT-CITY OF BALTIMORE

D 61865

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Volunteers of America Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 418 W. Lexington ST. 17 WARD)

2-FULL NAME

Dr. Franklin H. Erb

(a) RESIDENCE. NO. 2112 N. Charles ST. WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Mary E. J. Erb

6 DATE OF BIRTH (month, day, and year)

April 7, 1849

7 AGE

62

10

27

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Doctor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Samuel W. Erb

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Ella Bente

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Mary E. J. Erb 2112 N. Charles St. Baltimore

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 28, 1922, to Feb. 28, 1922,

that I last saw him alive on Feb. 28, 1922, and that death occurred, on the date stated above, at 1:50 p. m.

The CAUSE OF DEATH\* was as follows:

acute Prostatitis - acute Septic arthritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Gen. Septicemia (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? 2112 N. Charles St.

Did an operation precede death? Yes Date of Feb. 16

Was there an autopsy? No

What test confirmed diagnosis? Laboratory - Staph. aureus on pyogenic in the blood

(Signed) J. F. Johnson M. D.

, 19 (Address) 418 W. Lexington St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Kinders Cemetery

UNDERTAKER Carroll W. M. J. F. Johnson

DATE OF BURIAL

Mar 3 1922

ADDRESS

Rustington

2-1922

Burial Permit Clerk



HEALTH DEPARTMENT—CITY OF BALTIMORE **D 61866****61866**

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2426 Liberty Heights Ave ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mary B. Bowen

## (a) RESIDENCE

No. 2426 Liberty Heights Ave ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

William Bowen6 DATE OF BIRTH (month, day, and year) July 21 18567 AGE Years Months Days If LESS than 1 day, hrs. or min. 66 - 7

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore MD

10 NAME OF FATHER

David Wilhelm

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore MD

12 MAIDEN NAME OF MOTHER

Margaret Hoover

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore MD

14

Informant (Address)

George C. Bowen 2426 Liberty Heights Ave

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) FEB 28 19 2217 I HEREBY CERTIFY, That I attended deceased from Feb 22, 19 22, to Feb 28, 19 22.that I last saw her alive on Feb 27, 19 22.and that death occurred, on the date stated above, at 4:00 A. M.

The CAUSE OF DEATH\* was as follows:

Influenza(duration) yrs. mos. ds. 7CONTRIBUTORY Septic Bronchitis(Secondary) (duration) yrs. mos. ds. 6

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? none(Signed) Ronald E. Beach, M. D., 19 (Address) 2231 St Paul st

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Landon Park Cemetery March 3 1922

20 UNDERTAKER ADDRESS

Chas. S. Black 742 W. North Ave

D 61867

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61867

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *North St. & Dinnin* ST. 19 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. *309 N. Gilman* ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs. mos. ds.(If nonresident give city or town and State)  
How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Henry Clay Wallace*

6 DATE OF BIRTH (month, day, and year)

7 AGE

*79*

Years

Months

Days

If LESS than  
1 day. hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)14 Informant  
(Address)

15 Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb. 27* 19 *22*

17 I HEREBY CERTIFY, That I attended deceased from

*Feb. 23, 1922, to Feb. 26, 1922*that I last saw him alive on *Feb. 26, 1922*and that death occurred, on the date stated above, at *3 A.* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Valvular Heart Disease*(duration) *2* yrs. mos. ds.CONTRIBUTORY  
(Secondary)(duration) *—* yrs. *—* mos. *—* ds.18 Where was disease contracted  
If not at place of death?Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *John D. Quinn, M. D.*Address *1507 N. Fulton Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*St. Paul, Md.* DATE OF BURIAL *Feb. 3* 19 *22*

20 UNDERTAKER

*James H. Quinn* ADDRESS *3rd*

D 61868

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61868

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *504 Harris*)ST.: *19* WARD)

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Rebecca Craddock*(a) RESIDENCE. No. *504 Harris*

ST. ....

WARD. ....

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *10* yrs. .... mos. .... ds. ....

How long in U. S., if of foreign birth? yrs. .... mos. .... ds. ....

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*Colored*

## 5 Single, Married, Widowed, or Divorced (write the word)

*married*

## 5a If married, widowed, or divorced

*HUSBAND of*  
(or) WIFE of*Archon Craddock*6 DATE OF BIRTH (month, day, and year) *Mar. 1-1887*

## 7 AGE

*34* Years

Months

Days

If LESS than  
1 day, .... hrs.  
or .... min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Domestic*

(b) General nature of industry, business, or establishment in which employed (or employer)

*General  
housework*

(c) Name of employer

*Private families*9 BIRTHPLACE (city or town)  
(State or country)*Kent Co. Md.*

## 10 NAME OF FATHER

*Geo. Anderson*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Kent Co. Md.*

## 12 MAIDEN NAME OF MOTHER

*not known*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*not known*

## 14

Informant  
(Address)*Archon Craddock  
504 Harris St.*

## 15

Filed

*Robert F. Harrison,*

Registrar

1922

Burial Permit Clerk?

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb-28* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb. 26*, 19*22*, to *Feb. 28*, 19*22*.that I last saw her alive on *Feb. 27*, 19*22*.and that death occurred, on the date stated above, at *4-30 A.* m.

The CAUSE OF DEATH\* was as follows:

*Cerebral hemorrhage*(duration) .... yrs. .... mos. *2* ds.CONTRIBUTORY  
(Secondary)

(duration) .... yrs. .... mos. .... ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Chas. L. McCarty, M. D.*

, 19

(Address)

*906 N. Street*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*St. Gabriel Cemetery**Feb. 3* 19*22*

## 20 UNDERTAKER

## ADDRESS

*James H. Oliver**1202*

# CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

Woman seemed much older than age given to physician. No evidence of liver. Primary cerebral hemorrhage.



D 61869

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61869

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

*St. Joseph Hospital*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.:

WARD)

2-FULL NAME

*Ernest Gall*

(a) RESIDENCE. NO.

*Rowlesburg W. Va.*

ST.:

WARD

*Rowlesburg W. Va.*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

9.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*1882*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*39**11**2*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Engineer 173*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Barbours W. Va.*

10 NAME OF FATHER

*Ch. Gall*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Barbours W. Va.*

12 MAIDEN NAME OF MOTHER

*J. E. Shroyer*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Co. W. Va.*

14

Informant (Address)

*Geo. S. Gall Rowlesburg W. Va.*

15

Filed

19

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3/1*19*22*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb. 20*19*22*to *March 1*19*22*

that I last saw him alive on

*March 1*19*22*

and that death occurred, on the date stated above, at

*7:10 P. m.*

The CAUSE OF DEATH\* was as follows:

*Myocardial Infarction.*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Chronic Intestinal Disease*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

*PS + S + Lab. naty.*(Signed) *Harold C. Pillsbury* M. D.19 (Address) *415 Cedarcroft Rd.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*ROWLESBURG WVA**MAR 4 1922*

20 UNDERTAKER

*ROBERT BROOKS, SON**CALNOUN ST*

2-1922

D 61870

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61870

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *negro* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, *March 14, 1921*  
(Month) (Day) (Year)

7-AGE, *11 yrs. 11 mos. 14 ds.* If LESS than 1 day, ...hrs. or...min.

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE, (State or Country), *Balto. Md.*

10-NAME OF FATHER, *James Lewis*  
11-BIRTHPLACE OF FATHER (State or Country), *not known*  
12-MAIDEN NAME OF MOTHER, *Susan Lewis*  
13-BIRTHPLACE OF MOTHER (State or Country), *not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Robert P. Harrison, REGISTRAR.

2-1922 Burial Permit Clerk, Registrar.

18960

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *March 1, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *November 1921* to *February 26, 1922*, that I saw her alive on *February 26, 1922*, and that death occurred, on the date stated above, at *9 A. m.*  
The CAUSE OF DEATH\* was as follows:

*Chronic Gastric Intestitis*  
(Duration).....yrs. *4* mos. ....ds.  
CONTRIBUTORY.....*Decomposition*  
(Secondary) (Duration).....yrs. *1* mos. ....ds.  
(Signed) *Frank J. Ayth* M. D.  
*Mar 1, 1922* (Address) *305 E. Monument St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

Commissioner Health,

For. Wm. E. WOODALL.

MAR 2 1922

5-39 61871 HEALTH DEPARTMENT—CITY OF BALTIMORE 61871

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. If of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD)

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 1-1884

7 AGE

Years

Months

Days

If LESS than 1 day, hrs.

or min.

37

4

23

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

New Jersey

10 NAME OF FATHER

Harrison

PARENTS

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

Robert P. Harrison

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb. 23<sup>rd</sup> 1922

17

HEREBY CERTIFY, That I attended deceased from

Feb. 18<sup>th</sup>, 1922, to Feb. 23<sup>rd</sup>, 1922

that I last saw him alive on Feb. 23<sup>rd</sup>, 1922

and that death occurred, on the date stated above, at 12<sup>35</sup> P. M.

The CAUSE OF DEATH\* was as follows:

1. Anemia

(duration) yrs. mos. 7 da.

CONTRIBUTORY (Secondary).

Chronic nephritis & hypertension

(duration) 2 yrs. mos. da.

18 Where was disease contracted

If not at place of death?

At home

Did an operation precede death?

No

Was there an autopsy?

What test confirmed diagnosis?

Blood Chemistry

(Signed) Francis R. Dienaide, M. D.

Feb 23, 1922 (Address) Johns Hopkins Hospital

\*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

Commissioner Health,

ADDRESS

MAR 2 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61872

## CERTIFICATE OF DEATH.

90 D 61872

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 240 Dr. Clinton ST., 6 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Laura Kelly

## (a) RESIDENCE NO.

207 Dr. Port-

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 3 mos. 0 ds.

ST.,

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 4 yrs. 3 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

James Kelly

6 DATE OF BIRTH (month, day, and year)

March 13 1852

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

691115

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

Robert - Surge

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

St. Louis

12 MAIDEN NAME OF MOTHER

Ruth Poole

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

14

Informant (Address)

John T. Pinder  
240 Dr. Clinton St.

15

Filed Robert P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 192217 I HEREBY CERTIFY, That I attended deceased from June 10 1918 to March 2 1922.that I last saw him alive on 4 28 1922.and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Malnutrition  
Heart  
Failure

CONTRIBUTORY (Secondary)

(duration) 2 yrs. 0 mos. 0 ds.(duration) old age yrs. 0 mos. 0 ds.18 Where was disease contracted if not at place of death? HomeDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) A. C. Kraus M. D.y. 1922 (Address) 2400 E. Maltby St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. LouisMarch 4 1922

20 UNDERTAKER

ADDRESS

Wm. CookSt. Louis

10000 Burial Permit Clerk



D 61873

## HEALTH DEPARTMENT-CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

1402. Towson.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Annie R. Sakowski

(Residence in Baltimore: No.

1402 Towson

St. 25 yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(If write the word)

widowed

6 DATE OF BIRTH

March 15, 1865

(Month)

(Day)

(Year)

7 AGE

56 yrs. 11 mos. 3 ds.

If LESS than

1 day, hrs.

or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Housework, 100

9 BIRTHPLACE  
(State or country)

Germany

10 NAME OF FATHER

Unknown

PARENTS

11 BIRTHPLACE OF FATHER  
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER  
(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph W. Sakowski

(Address)

1402 Towson St

15.

Robert P. Harrison,

Filed

191

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

February 18, 1912

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1912, to February 18, 1912

that I saw her alive on February 17, 1912

and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Stomach

(Duration) 1 yrs. 0 mos. 3 ds

Contributory  
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

Thos. Stevens

M. D.

3/1, 1912

(Address)

2878 Hampden Rd

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

New Catholic Church

DATE OF BURIAL

Feb. 17, 1912

20 UNDERTAKER

J. M. Cook

ADDRESS

1402 Towson St

is very important. See instructions on back of certificate.

1922

Permit Clerk

(Marrglia) ✓

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61874

## CERTIFICATE OF DEATH.

REGISTERED NO. C. 100-000 61874

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 N Pearl St.)

## 2-FULL NAME

(Residence in Baltimore: No. 306 Pearl St.)

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *female* 4-COLOR OR RACE. *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH. *2-13-1922*  
(Month) (Day) (Year)

## 7-AGE,

yrs. *15* mos. *5* ds.If LESS than 1 day,  
...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,  
(State or Country),*Baltimore Md*

## 10-NAME OF FATHER,

*Antonio Marrglia*11-BIRTHPLACE OF FATHER  
(State or Country),*Italy*

## 12-MAIDEN NAME OF MOTHER

*Carmela Marrglia*13-BIRTHPLACE OF MOTHER  
(State or Country),*Italy*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Dimora*(Address) *1318 Light St*

## 15-

*Robert P. Harrison,*Filed *2-1922*Burial Permit *016* Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*3-1-1922*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *2-28-1922* to *3-1-1922*that I saw her alive on *3-1-1922*and that death occurred, on the date stated above, at *3-1-1922* m.

The CAUSE OF DEATH\* was as follows:

*Pneumonia*(Duration) *3* yrs. *3* mos. *3* ds.CONTRIBUTORY  
(Secondary)(Duration) *2* yrs. *3* mos. *3* ds.(Signed) *Chas. J. J. J.*101... (Address) *1318 Light St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *3* yrs. *3* mos. *3* ds. In the State *3* yrs. *3* mos. *3* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

## 20-UNDERTAKER

## ADDRESS

*St Vincent's Cem*  
*John J. J. J.**2-3-22*  
*1318 Light St*

D 61875

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61875

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_)

2-FULL NAME

(Residence in Baltimore: No. \_\_\_\_\_)

ST.;

WARD)

REGISTERED NO. C \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 22 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) \_\_\_\_\_

(Address) \_\_\_\_\_

15-

Filed \_\_\_\_\_

Robert P. Harrison, Jr.

191 \_\_\_\_\_

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

I HEREBY CERTIFY, That I attended deceased from

Feb 26/22 191, to Nov 2/1922

that I saw her alive on Nov 1/1922,

and that death occurred, on the date stated above, at 1:20 p.m.

The CAUSE OF DEATH\* was as follows:

Lithaemia Gravidarum

Duration 9 mos. 9 ds.

CONTRIBUTORY (Secondary)

(Signed) J. H. B. M. D.

Nov 2, 191 (Address) 1203 1/2 St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. 3 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 521 E. Clement

Former or usual residence 521 E. Clement

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Linden Park Cemetery, March 4, 1922

20-UNDERTAKER, ADDRESS

Mrs. J. E. Evanson, 1428 N. E. St.

D 61876

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61876

## CERTIFICATE OF DEATH.

31

## 1-PLACE OF DEATH

CITY OF BALTIMORE:

308 S Pulaski ST.

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

John Linsenmeyer

## (a) RESIDENCE NO.

308 S Pulaski ST.

WARD.

(Usual place of abode)  
Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

male

## 4 COLOR OR RACE

Wht.

## 5 Single, Married, Widowed, or Divorced (write the word)

married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary Linsenmeyer

## 6 DATE OF BIRTH (month, day, and year)

Feb. 14 - 1884

## 7 AGE

38 Years Months Days

38 14

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Bottle Bar

## (b) General nature of industry, business, or establishment in which employed (or employer)

Wagon Driver

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Balt. Md.

## 10 NAME OF FATHER

John P. Linsenmeyer

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt. Md.

## 12 MAIDEN NAME OF MOTHER

Elizabeth Smith

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt. Md.

## 14 Informant (Address)

Mary Linsenmeyer 308 S. Pulaski St.

## 15 Registrar

Robert E. Harrison

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 1 1922

## 17 I HEREBY CERTIFY, That I attended deceased from

Jan 1 1922, to March 1 1922

## that I last saw him alive on

March 1 1922

## and that death occurred, on the date stated above, at

10<sup>00</sup> a. m.

## The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

## (duration)

Unknown

## CONTRIBUTORY (Secondary)

Endocarditis &amp; Pulmonary

## (duration)

2 yrs. 2 mos. 2 ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

## Was there an autopsy?

What test confirmed diagnosis?

## (Signed)

Norbert C. Kitch M. D.

## Address

2151 N. T. Ave.

## \*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral

## DATE OF BURIAL

Mar 2 1922

## 20 UNDERTAKER

Geo. L. Schwal

## ADDRESS

3101 E. Ave.

2-1922

Burial Permit Clerk



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61877

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1222 W. Lafayette Ave. ST. 16 WARD)

## 2. FULL NAME

(s) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds.

How long in U. S., if of foreign birth? 60 yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

5a If married, widowed, or divorced HUSBAND of (or) SUSANNA HERRERA

6 DATE OF BIRTH (month, day, and year)

7 AGE

80

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Spain

10 NAME OF FATHER

Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Spain

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Spain

14

Informant (Address)

Susanna Herrera

1222 W. Lafayette Ave.

15

Robert P. Harrison,

Burial Permit Clerk.

Registrar

16 DATE OF DEATH (month, day, and year) March 1 - 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 1922, to March 1, 1922.

that I last saw him alive on March 1, 1922.

and that death occurred, on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial

nephritis.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

old age

18 Where was disease contracted if not at place of death?

Don't know

Did an operation precede death?

no

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Geo W. Hemminger, M. D.

3-2, 1922 (Address)

800 Harbor Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Manda Chapel Mar 4 1922

20 UNDERTAKER

Geo W. Little

ADDRESS

1700

Edmondson Ave

(William Sylvester Shauffer) ✓  
HEALTH DEPARTMENT—CITY OF BALTIMORE D 61878

D 61878

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed,  
or Divorced, (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

5/30/1863

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Baggage-master

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

Penn R.R.

9 BIRTHPLACE (city or town)  
(State or country)

Pa

10 NAME OF FATHER

J. F. Shauffer

11 BIRTHPLACE OF FATHER (city or town)

Pa

(State or country)

12 MAIDEN NAME OF MOTHER

Lily Kummer

13 BIRTHPLACE OF MOTHER (city or town)

Pa

(State or country)

14

Informant  
(Address)

B. F. Free

2125 Huntington Ave

15

Filed

Robert P. Harrison,

19

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/2 1922

17

I HEREBY CERTIFY, That I attended deceased from

2/24, 1922 to 3/2, 1922

that I last saw him alive on

3/2, 1922

and that death occurred, on the date stated above, at

7:45 a.m.

The CAUSE OF DEATH\* was as follows:

Cardiomegaly of heart (Diabetes)  
chronic nephritis, uremia  
Insufficiency

(duration) yrs. 12 mos. ds.

CONTRIBUTORY  
(Secondary)

Septicemia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted  
if not at place of death?

2125 Huntington Ave

Did an operation precede death?

yes Date of 2/24/22

Was there an autopsy?

yes

What test confirmed diagnosis?

lung

(Signed)

W. S. Shauffer, M. D.

19 (Address)

Maryland General Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Freelands Shd

Mar 5 1922

20 UNDERTAKER

ADDRESS

Geo W Little

2700

Edmondson

61879

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61879

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3708 Elm Ave. ST. 13 WARD)

## 2. FULL NAME

(a) RESIDENCE No. 3708 Elm Ave. ST. 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15 - 18527 AGE Years 69 Months 11 Days 14 If LESS than 1 day, ... hrs or ... min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Co. Maryland10 NAME OF FATHER John H. Creeland11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Co. Maryland12 MAIDEN NAME OF MOTHER Harriet M. Commey13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hayford Co. Maryland

## PARENTS

14 Informant Wm. C. Houser (Address) 3708 Elm Ave.15 2-1922 Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 192217 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1921, to Mar 1st, 1922, that I last saw her alive on Mar 1st, 1922, and that death occurred, on the date stated above, at 3:40 A. m. The CAUSE OF DEATH\* was as follows:Carcinoma of Gall Bladder & Liver.(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? clinical(Signed) James D. ... M. D.Address 846 W 36 St Baltimore

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Hayford Baptist (Balt Co) DATE OF BURIAL March 3, 1922

20 UNDERTAKER

Horace H. Burgee ADDRESS 3631 Falls Rd

D 61880

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61880

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Maryland General Hospital

ST. 28 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Emma H. Schultz

## (a) RESIDENCE. No.

3410 Morton Ave

(Usual place of abode)

## WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

41 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

41 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

male

## 4 COLOR OR RACE

white

## 5 Single, Married, Widowed, or Divorced (write the word)

married

## 5a If married, widowed, or divorced

HUSBAND of  
WIFE of

Emma H. Schultz

## 6 DATE OF BIRTH (month, day, and year)

11/29/1859

## 7 AGE

Years

Months

Days

If LESS than

62

2

28

1 day, hrs.

or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Silversmith

(b) General nature of industry, business, or establishment in which employed (or employer)

OR

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Sweden

## 10 NAME OF FATHER

Carl J. Schultz

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Sweden

## 12 MAIDEN NAME OF MOTHER

Annie Holberg

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Sweden

## 14

Informant  
(Address)Emma H. Schultz  
3410 Morton Ave

## 15

Filed

Robert P. Harrison,

Registrar

-1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

2/28 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb. 22, 1922, to Feb 28, 1922

that I last saw him alive on

2/28 1922

and that death occurred, on the date stated above, at

9:20 P.M.

The CAUSE OF DEATH\* was as follows:

Gastric ulcer -  
Gastric carcinoma - Perforation -  
Peritonitis.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

Cardiac Decompensation

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

3410 Morton Ave Baltimore

Did an operation precede death?

yes Date of 2/27/22

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical

(Signed)

W. D. Douglass, M.D.

, 19 (Address)

Maryland General Hospital

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Lorraine Cem

Mar 3 1922

## 20 UNDERTAKER

## ADDRESS

Wm. Lickner &amp; Sons

N. Pa





D 61882

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61882

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1835 W. Mulberry ST., 20 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Hannie L. Hopkins

## (a) RESIDENCE NO.

1835 W. Mulberry ST.,

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 10 mos. 1 ds.How long in U. S., if of foreign birth? 1 yrs. 10 mos. 1 ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female White

## 4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John T. Hopkins

## 6 DATE OF BIRTH (month, day, and year)

Apr 29, 1865

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

56101

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

## 10 NAME OF FATHER

Patrick Holland

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

## 12 MAIDEN NAME OF MOTHER

Mary Cowley

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

## 14

Informant (Address)

Gerald P. Hopkins  
1835 W. Mulberry

## 15

Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 12, 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

June 1st, 1921, to March 12, 1922  
that I last saw her alive on March 12, 1922,  
and that death occurred, on the date stated above, at 8:00 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Anemia

## CONTRIBUTORY (Secondary)

(duration) yrs. 9 mos. — ds.(duration) yrs. — mos. — ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Elmer B. Truman, M.D.19 (Address) 412 Castleton St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral Cem

## DATE OF BURIAL

3/4 1922

## 20 UNDERTAKER

Wm. J. Hickman & Sons

## ADDRESS

North Pa

TION is very important

2-1922

Bureau of Health

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1725)

FULL NAME

(Residence in Baltimore: No. 1725)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH

7-AGE

IF LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or Country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

2-1922

Funeral Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, and from the evidence obtained by said inquest, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

(Coroner)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

D 61884

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61884

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3509 Chestnut Ave. 13 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie V. Price(a) RESIDENCE. NO. 3509 Chestnut Ave. ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Daniel W. Price6 DATE OF BIRTH (month, day, and year) April 9, 18517 AGE Years 70 Months 10 Days 21 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto; Co. Md. (State or country)10 NAME OF FATHER John Turnbaugh11 BIRTHPLACE OF FATHER (city or town) Balto; Co. Md. (State or country)12 MAIDEN NAME OF MOTHER Cassandra Lowe13 BIRTHPLACE OF MOTHER (city or town) Fredrick Co. Md. (State or country)14 Informant Daniel W. Price (Address) 3509 Chestnut Ave.15 Filed Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28, 192217 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1922, to Feb. 28, 1922, that I last saw her alive on Feb. 28, 1922, and that death occurred, on the date stated above, at 9:52 P. m.

The CAUSE OF DEATH\* was as follows:

Acute Pulmonary EdemaCONTRIBUTORY Chronic Interstitial Nephritis 1 wk. Acute Influenza 1 wk. Initial Respiratory Infection

18 Where was disease contracted? If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Machin M. D., 19 (Address) 4119 Falls Road

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys (Harpsden) DATE OF BURIAL Feb 3 1922

20 UNDERTAKER

E. Le Roy Stiffles ADDRESS 1258 North Ave

1922

Baltimore Health Dept.



Chase  
HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1448 Parish

ST. 15 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1448 Parish

St.: 41 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE

Coe

5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word.)

## 6-DATE OF BIRTH

7

## 7-AGE

47

IF LESS than 1 day.  
...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE  
(State or Country)

## 10-NAME OF FATHER

11-BIRTHPLACE OF FATHER  
(State or Country)

## 12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country)

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

MAR 3 - 1922

ROBERT R. KRAUTER,

Burial Permit Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

March 1, 1922

(Month)

(Day)

(Year)

HEREBY CERTIFY, That I attended deceased from

that I saw her alive on Feb 28, 1922

and that death occurred, on the date stated above, at 9 p m.

THE CAUSE OF DEATH\* was as follows:

Subacute Rheumatism

CONTRIBUTORY  
(Secondary)

(Signed)

MAR 1, 1922

(Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

St. Pauline Cemetery

## 20-UNDERTAKER

Henry H. Dennis

## DATE OF BURIAL

Feb 28, 1922

## ADDRESS

1303

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61886

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 11 Stricker ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Bell(a) RESIDENCE. NO. 12 11 Stricker ST. 16 WARD.  
(Usual place of abode)  
Length of residence in city or town where death occurred 19 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced  
HUSBAND of Reason Bell  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Feb 28, 18527 AGE Years 70 Months - Days 1  
If LESS than 1 day, hrs. - or min. -

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self9 BIRTHPLACE (city or town) Prince George Co.  
(State or country)10 NAME OF FATHER Joseph Harper11 BIRTHPLACE OF FATHER (city or town) Prince George Co.  
(State or country)12 MAIDEN NAME OF MOTHER Anna Proctor13 BIRTHPLACE OF MOTHER (city or town) Prince George Co.  
(State or country)

14

Informant  
(Address) Katella Carey  
1211 Stricker

15

MAR 3 - 1922

ROBERT R. KRAUTER,  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 192217 I HEREBY CERTIFY, That I attended deceased from Jan 9 19 22, to March 1 19 22  
that I last saw her alive on February 28 19 22,  
and that death occurred, on the date stated above, at 3.05 A m.  
The CAUSE OF DEATH\* was as follows:Cerebral Stenosis  
(duration) yrs. 1 mos. 20 ds.  
CONTRIBUTORY Age - Arteriosclerosis  
(Secondary) (duration) yrs. 0 mos. 0 ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physical(Signed) William H. Wright M. D.  
(Address) 1709 Parkman St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mr. Auburn Underhill March 3 1922  
20 UNDERTAKER James J. Davis Greensboro

D 61887

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61887

61887

## CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 27)

WARD)

FULL NAME

(Residence in Baltimore: No. 500 Strohman Ave

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 3 mos. 20 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

MAR 3 - 1922

ROBERT R. KRAUTER,  
Burial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

(Coroner)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61888

## CERTIFICATE OF DEATH.

REGISTERED NO.

D 61888

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2026 Wilkens Ave.,

ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Shulman

(a) RESIDENCE NO. 2026 Wilkens Avenue

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Shulman

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE 45 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Barel Sobel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis Shulman (Address) 2026 Wilkens Ave.

15 MAR 3 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/2 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10th 1921 to Mar. 2, 1922, that I last saw her alive on Mar. 2, 1922, and that death occurred, on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH\* was as follows:

Myocarditis

CONTRIBUTORY (Secondary)

duration) 1 1/2 yrs. mos. ds.

duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Nathan R. Budenberg, M. D.

3/2, 1922 (Address) 2114 Wilkens Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61889

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1341 Sargeant* ST. *21* WARD)

## 2-FULL NAME

(a) RESIDENCE. NO. *1341 Sargeant* ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *1* yrs. *11* mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb 1 1921*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAR 3 - 1922

ROBERT KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 2 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 28*, 19*21*, to *March 2*, 19*22*.that I last saw him alive on *Feb 28*, 19*21*.and that death occurred, on the date stated above, at *2:18* p.m.

The CAUSE OF DEATH\* was as follows:

*Bronch Pneumonia*(duration) yrs. mos. ds. *3*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Joseph A. Davis*, M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*for foerchens Son**217 S. B.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61891

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin St. Hospital*)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *1703 E 28th*)

St.; yrs., mos., ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>M.</i>	4-COLOR OR RACE. <i>W</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) <i>married</i>
6-DATE OF BIRTH. <i>Aug - 16, 1887</i> (Month) (Day) (Year)		
7-AGE. <i>34</i> yrs. <i>6</i> mos. <i>10</i> ds.		8-LESS than 1 day. hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). <i>Coffin maker</i> <i>086</i>		

9-BIRTHPLACE.  
(State or Country), *Balto*

PARENTS.	10-NAME OF FATHER. <i>Frederick H.</i>
	11-BIRTHPLACE OF FATHER (State or Country), <i>md.</i>
	12-MAIDEN NAME OF MOTHER <i>Mary J. Ward</i>
	13-BIRTHPLACE OF MOTHER (State or Country), <i>md.</i>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Hospital Records*

(Address) .....

MAR 3 - 1922

Filed....., 191.

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.  
*Feb - 28, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *2/26 - 1922*, to *2/28 - 1922*, that I saw him alive on *2/28 - 1922*, and that death occurred, on the date stated above, at *3:45 P. m.*

The CAUSE OF DEATH\* was as follows:

*Acute Pericarditis*

(Duration).....yrs.....mos.....ds.  
CONTRIBUTORY.....*Myocardial Coronary*  
(Secondary)

(Duration).....yrs.....mos.....ds.  
(Signed).....*Newton J. Davis*.....M. D.  
*2/28, 1922* (Address).....*Franklin St. Hosp.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, *Baltimore Cemetery* DATE OF BURIAL, *March 1, 1922*20-UNDERTAKER *James Lignan & Son* ADDRESS *1000 S. Pass St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 61892

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 Warner ST., 22 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

67 yrs. 4 mos. 19 ds.

ST., WARD

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

MAR 3 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 16, 1922 to Mar 1, 1922

that I last saw him alive on Mar 1, 1922

and that death occurred, on the date stated above, at 12 - m.

The CAUSE OF DEATH\* was as follows:

Mitral Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyd, M. D.

2-5, 1922 (Address) 607 Columbia

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



D 61893

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 N. Calhoun ST., 19 WARD)

## 2-FULL NAME

Mary Elizabeth Gibbon

## (a) RESIDENCE NO.

11 N. Calhoun

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John Gibbon

6 DATE OF BIRTH (month, day, and year)

Nov 11, 1851

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

70319

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Hadley, Mass

10 NAME OF FATHER

Chester Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Hadley Mass

12 MAIDEN NAME OF MOTHER

Mary ANN Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Hadley Mass

PARENTS

14

Informant (Address)

Mrs. Henry Stockbridge  
11 N. Calhoun St

15

MAR 3 - 1922ROBERT R. KRAUTER,  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 2, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 25, 1921, to March 2, 1922that I last saw her alive on March 2, 1922and that death occurred, on the date stated above, at 8:32 A.M.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis, cerebral thrombosis, chronic interstitial nephritis.(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Acute cardiac decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Lawrence S. S. M. D., 19 (Address) 1111 W. Lenoire St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Hadley Mass. March 3, 1922

20 UNDERTAKER

John Mitchell 1201 W. Fayette St.

D 61894

D-61894

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 Light St.

ST. 23 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie E. Thornton

(a) RESIDENCE. No. 1108 Light St.

(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 9 mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Edward Thornton

6 DATE OF BIRTH (month, day, and year) May 23 1894

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

27 9 4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

10 NAME OF FATHER John H. Scheeler

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Emma Metzker

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)

14 Informant Mrs John H. Scheeler (Address) 1108 Light St.

15 MAR 3 - 1922 J. E. Kohn Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2 1922

17

I HEREBY CERTIFY, That I attended deceased from July 10, 1922, to Mar 1, 1922, that I last saw her alive on Mar 1, 1922, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual signs

(Signed) W. S. Smith, M. D.

19 (Address) 109 W. Lee St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cedar Hill Cemetery

3/4 1922

20 UNDERTAKER

ADDRESS

J. F. M. Conley

130 E. Ford.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D-61895  
D 61895

## CERTIFICATE OF DEATH.

370 ✓ 61895  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 533 Wilson

ST. 14

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME Alice Johnson

(Residence in Baltimore: No. 533 Wilson

St.; 30 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX. F

## 4-COLOR OR RACE, Black

5-STATUS.  
MARRIED, *Mom*  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

## 6-DATE OF BIRTH, Jan 10, 1875

(Month)

(Day)

(Year)

## 7-AGE, 46 yrs. 8 mos. 20 ds.

If LESS than 1 day.

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife 037

## 9-BIRTHPLACE, (State or Country), Maryland (Calvert Co)

## 10-NAME OF FATHER, Henry Belknap

## 11-BIRTHPLACE OF FATHER

(State or Country), Calvert Co Md

## 12-MAIDEN NAME OF MOTHER, Ellen Belknap

## 13-BIRTHPLACE OF MOTHER

(State or Country), Calvert Co Md

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anne Brown

(Address) 533 Wilson St

15- MAR 2 - 1922

Filed. 191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH, Feb 28, 1922

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from Jan 10, 1922, to Feb 28, 1922,

that I saw him alive on Feb 24, 1922,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Pneumonia, tubercular

## CONTRIBUTORY (Secondary)

(Duration) 1 yrs. mos. ds.

(Signed) M. D.

Mar 7, 1922 (Address) 1204 Gordon St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

## DATE OF BURIAL, March 3, 1922

## 20-UNDERTAKER, John H. Owen

## ADDRESS, 538 Solferino St

D-61896 Burgess B Allen D-61896  
HEALTH DEPARTMENT—CITY OF BALTIMORE  
D 61896  
CERTIFICATE OF DEATH.  
1-PLACE OF DEATH  
City of BALTIMORE: (No. 1614 South St., 3 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
2-FULL NAME Burgess B Allen  
(Residence in Baltimore: No. 1614 South St.; yrs. 60 mos. 00 ds.)

PERSONAL AND STATISTICAL PARTICULARS.  
3-SEX, Male  
4-COLOR OR RACE, white  
5-Single, Married, Widowed, or Divorced, Married  
6-DATE OF BIRTH, Oct 3 1858  
7-AGE, 63 yrs. 4 mos. 36 ds.  
8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, School  
(b) General nature of industry, business, or establishment in which employed (or employer),  
9-BIRTHPLACE, (State or Country), Davis, Georgia  
10-NAME OF FATHER, William Allen  
11-BIRTHPLACE OF FATHER, (State or Country), England  
12-MAIDEN NAME OF MOTHER, Not Known  
13-BIRTHPLACE OF MOTHER, (State or Country), Not Known  
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant), Minnie Allen  
(Address), 1614 South St.  
15-Filed, MAR 3 - 1922  
192 Registrars.

CORONER'S CERTIFICATE OF DEATH.  
16-DATE OF DEATH, March 1 1922  
(Month) (Day) (Year)  
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry,) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry,) And that said deceased came to death on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
Cerebral Apoplexy  
(Duration) yrs. mos. ds.  
CONTRIBUTORY (Secondary)  
(Duration) yrs. mos. ds.  
(Signed) Harry Shaw M.D. (Coroner)  
1922 (Address) 1804 North St.  
\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.  
18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).  
At place of death, yrs. mos. ds. In the State, yrs. mos. ds.  
Where was disease contracted, if not at place of death?  
Former or usual residence  
19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cemetery  
DATE OF BURIAL, March 3, 1922  
20-UNDERTAKER, H. Underhill  
ADDRESS, 1710 North St.



Lambert Butler  
HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 W. 21 WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. ds.

yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 23 1922 to Feb 28 1922 that I last saw him live on Feb 22 1922

and that death occurred, on the date stated above, at 10/10 m.

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia

(duration) no yrs. no mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? ex amittis

What test confirmed diagnosis?

(Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

14 Informant (Address)

15

Filed

MAR 2 1922

Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D-61898

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1)

2-FULL NAME

(a) RESIDENCE, No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 20, 1922, to March 2, 1922

that I last saw her alive on March 2, 1922

and that death occurred, on the date stated above, at 10:40 p.m.

The CAUSE OF DEATH\* was as follows:

Diphtheria, nasal, tonsillar + pharyngeal (duration) yrs. 1 mos. 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 7 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

M. D.

3/3/22

Address

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

MAR 3 - 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61899

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *315 E. Sayvale* WARD)

## 2-FULL NAME

*Henrietta Leicht*

## (a) RESIDENCE NO.

*315 E. Sayvale*

ST.

WARD

(Usual place of abode)

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred *12* yrs. mos. ds.How long in U. S., if of foreign birth? *12* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed,

*Widow*

## 5a If married, widowed, or divorced

HUSBAND or

(or) WIFE of

*Philip H. Leicht*

## 6 DATE OF BIRTH (month, day, and year)

*June 1, 1849*

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*72**9**—*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

*ood*

(c) Name of employer

## 9 BIRTHPLACE (city or town)

*Pa.*

(State or country)

## 10 NAME OF FATHER

*John Sheffer*

## 11 BIRTHPLACE OF FATHER (city or town)

*Pa.*

(State or country)

## 12 MAIDEN NAME OF MOTHER

*Hannah Behr*

## 13 BIRTHPLACE OF MOTHER (city or town)

*Pa.*

(State or country)

## 14

Informant  
(Address)*Mr. Lydia M. Hecker  
315 E. Sayvale*

## 15

File

*MAR 3 - 1922*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 1, 1922*

17

I HEREBY CERTIFY that I attended deceased from

*Jan. 1, 1922, to Feb. 27, 1922*that I last saw her alive on *Feb. 27, 1922*and that death occurred, on the date stated above, at *9:20 P. M.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Apoplexy*(duration) yrs. *1* mos. *29* ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*J. E. Buntz*  
*1531 E. North Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION, OR RE-

## DATE OF BURIAL

*Shrewsbury, Pa.**March 4, 1922*

## 20 UNDERTAKER

## ADDRESS

*Henry Ford, Son**1301 E. Eager*

D 61900

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61900

## CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 829 Edmundson St. 17

FULL NAME

(Residence in Baltimore: No. 829 Edmundson St.

REGISTERED No. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs.. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER,

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereon and from the evidence obtained by said

find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Coroner.)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS





## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61902

## CERTIFICATE OF DEATH.

117 D 61902

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3427 Rustleton Road 15 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Kenneth G. Clark

## (a) RESIDENCE, NO.

3427 Rustleton Road

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 6 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) July 5, 19087 AGE Years 13 Months 6 Days 27 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None(b) General nature of industry, business, or establishment in which employed (or employer) School Boy

(c) Name of employer

9 BIRTHPLACE (city or town) Baths Md.  
(State or country)10 NAME OF FATHER Wilbert G. Clark11 BIRTHPLACE OF FATHER (city or town) Md.  
(State or country)12 MAIDEN NAME OF MOTHER Mary B. Burgan13 BIRTHPLACE OF MOTHER (city or town) Md.  
(State or country)14 Informant Mr. Wilbert G. Clark  
(Address) 3427 Rustleton Rd15 MAR 3 - 1922 ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 19 2217 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 19 22, to March 2, 19 22.that I last saw him alive on March 2, 19 22.and that death occurred, on the date stated above, at          m.

The CAUSE OF DEATH\* was as follows:

Acute Infarction(duration) yrs. mos. 5 hoursCONTRIBUTORY operation for appendicitis  
(Secondary) Feb. 10 - 22, (duration) yrs. mos. 22 ds.18 Where was disease contracted at place of death  
if not at place of death?Did an operation precede death? yes Date of Feb 10 - 22Was there an autopsy? noWhat test confirmed diagnosis? Analysis of my infarct  
(Signed) Thomas Wilson, M. D., 19 (Address) 1001 1/2 Lullwater ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL March 4, 192220 UNDERTAKER H. M. Routron ADDRESS 225 F M 1  
North ave

D 61903

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 161-091 D 61903

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph Hospital* ST. *76* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *711 Boulden* ST., WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2/ ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Wid.*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *February 9 1922*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *21*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Md.*

10 NAME OF FATHER *John - L. Hoytowitz*

11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country) *Md.*

12 MAIDEN NAME OF MOTHER *Rebecca Hoytowitz*

13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country) *Md.*

14 Informant *Mrs. Cecelia Hoytowitz* (Address) *711 N. Boulden St.*

15 *MAR 3 - 1922* ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/2/22*

17 I HEREBY CERTIFY, That I attended deceased from *Feb 9* 1922, to *March 2* 1922, that I last saw her alive on *March 2* 1922, and that death occurred, on the date stated above, at *10 P.* m. The CAUSE OF DEATH\* was as follows:

*Premature birth*  
(duration) *3 weeks* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *No*

Was there an autopsy? *No*

What test confirmed diagnosis? *P. S. Hyphant*  
(Signed) *H. M. Freeman*, M. D.  
, 19 (Address) *2601 N. Calvert St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Holy Cross Cemetery* *March 3* 1922

20 UNDERTAKER

*Henry H. H. H.* ADDRESS *1301 E. Egan St.*

TION is very important. See instructions on reverse side.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61904

## CERTIFICATE OF DEATH.

D 61904

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Samuel M. Dexter

(a) RESIDENCE. NO.

600 S. East Ave.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept. 11<sup>th</sup> 1843

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

78

5

19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

John Dexter

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

Harnett

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15

MAR 3 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 2 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 5<sup>th</sup> 1922, to March 2<sup>nd</sup> 1922,

that I last saw him alive on March 2, 1922,

and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia

(duration) yrs. 1 mos. 25 ds.

CONTRIBUTORY  
(Secondary)

Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Routine Laboratory Tests.

(Signed) J. H. H. City, M. D.

, 19 (Address) J. H. H. City

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Carmel Cemetery

Mar 5 1922

20 UNDERTAKER

Girkler + Girkler

ADDRESS

1739 E. Egan St.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN

*Resided in Balto.*  
*over 30 years.*

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

**D 61905**

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)  
Length of residence in city or town where death occurred

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14 Informant (Address)

15 MAR 3 - 1922

ROBERT H. KRAUTER, Registrar  
Burial Permit Clerk

REGISTERED **D 61905**

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

WARD

(If nonresident give city or town and State)  
yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1922

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1922, to March 3, 1922, that I last saw him alive on March 2, 1922, and that death occurred, on the date stated above, at 1:00 a. m.  
The CAUSE OF DEATH\* was as follows:

Diphtheria, nasal, faucal & pharyngeal  
(duration) yrs. mos. ds. 45  
Contributory acute myocarditis  
(duration) yrs. mos. ds. 4

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no

Was there an autopsy? no

What test confirmed diagnosis? 3/3/22 Address: 1738 Oaklawn

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

Junkler & Junkler Eager

D 61906

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61906

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE (No. *1590 Hospital* ST. *W* WARD)2 FULL NAME *Everett Anderson*(Residence in Baltimore: No. *2038 E. Pratt St.*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *8* yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS

1-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Single*6-DATE OF BIRTH, *1*

(Month)

(Day)

(Year)

7-AGE, *34*

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Machine-helper*(b) General nature of industry, business, or establishment in which employed (or employer) *086*9-BIRTHPLACE, (State or Country), *Norway*

PARENTS.

10-NAME OF FATHER, *Don't know*11-BIRTHPLACE OF FATHER (State or Country), *Norway*12-MAIDEN NAME OF MOTHER *Don't know*13-BIRTHPLACE OF MOTHER (State or Country), *Norway*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Benj. Cohen*(Address) *1240 E. Madison*

15-

Filed

MAR 3 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk, Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Feb. 26, 1922*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.)

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Spinal. Throat cut with sharp razor.*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. H. Kelley* M. D.

(Coroner)

3-2-1922 (Address) *4 E. Pratt*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Trinity Cemetery**Mar. 2, 1922*

20-UNDERTAKER

ADDRESS

*John Herwig & Co**2008 Orleans*

important. See instructions on back of certificate.

D 61907

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61907

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 W 36 St)ST.: 13 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Cora E. Kieffer

## (a) RESIDENCE. NO.

811 W 36 St 2X

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) married5a If married, widowed, or divorced HUSBAND of Henry Kieffer (or WIFE of)6 DATE OF BIRTH (month, day, and year) Feb 5 - 18897 AGE Years 33 Months — Days 27 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Co, Md

## 10 NAME OF FATHER

John Miles

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Accomac, Cs. Virginia

## 12 MAIDEN NAME OF MOTHER

Rachel A. Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Hempstead, Co Maryland

## 14

Informant (Address)

John Miles 811 W 36 St

## 15

3 - 1922

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 192217 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1922, to Feb 22, 1922,that I last saw him alive on Feb 1st, 1922,and that death occurred, on the date stated above, at 10:30 A. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 22 Address 1427 Union St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St Mary's Hospital Mar 4 1922

20 UNDERTAKER

ADDRESS

W S Marshall 3539 Fall Rd.



D 61908

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 61908

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1311 Hallin

ST. 19

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Thomas E Long

(a) RESIDENCE. No. 1311 Hallin

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs 3 mos 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Ann B Long

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

64

3

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retailer

(b) General nature of industry, business, or establishment in which employed (or employer)

Wanted Hygiene Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baldwin

10 NAME OF FATHER

Thos. E Long

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Washington D C

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Washington D C

14

Informant (Address)

Ann B Long  
1311 Hallin

15

Filed

Robert P. Harrison,

Registrar

1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2<sup>nd</sup> 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 2<sup>nd</sup> 1921, to March 2<sup>nd</sup> 1922that I last saw him alive on March 2<sup>nd</sup> 1922.and that death occurred, on the date stated above, at 6<sup>00</sup> m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis

(duration) 1 yrs. 2 mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. 2 mos. 4 ds.

18 Where was disease contracted? If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinal

(Signed) E. J. Harrison M. D.

1/4, 1922 (Address) 517 Leaden

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park

Mar 6 1922

20 UNDERTAKER

ADDRESS

John Field 1200 N. Front

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61909

## CERTIFICATE OF DEATH.

179 D 61909

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1012 Patapsco St.

ST. 23 WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Annie Pletz.

## (a) RESIDENCE NO.

1012 Patapsco St.

ST. 23 WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 4 mos. 14 ds.

How long in U. S., if of foreign birth? — yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female. White. Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

George Pletz.

6 DATE OF BIRTH (month, day, and year) Oct. 15, 1861.

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

60 4 14

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

## 10 NAME OF FATHER

William Hinkel.

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany.

## 12 MAIDEN NAME OF MOTHER

Mary Ulrich.

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany.

## 14

Informant Minnie Myers. (daughter)  
(Address) 1012 Patapsco St.

## 15

Filed Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1st 1922

17 I HEREBY CERTIFY, That I attended deceased from February 17th 1922, to March 1st 1922.

that I last saw her alive on February 28th 1922.

and that death occurred, on the date stated above, at 1.45 p. m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis.

(duration) 2 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Uraemia.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed)

O. M. Reinhardt, M. D.

3/1, 1922 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Green Hill

## DATE OF BURIAL

3/4/1922

## 20 UNDERTAKER

E. J. Fanning 1460 Battery

3-1922

Burial Permit Clerk.

D 61910

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61910

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1028 E Lombard ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby LaFortezza(a) RESIDENCE, NO. 1028 E Lombard ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, 1 hrs. 30 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)10 NAME OF FATHER Ralph LaFortezza11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)12 MAIDEN NAME OF MOTHER Hattie Overholt13 BIRTHPLACE OF MOTHER (city or town) West (State or country) Virginia14 Informant Ralph LaFortezza (Address)15 Filed Robert P. Harrison, Registrar

3-1922

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 192217 I HEREBY CERTIFY, That I attended deceased from March 1, 1922, to March 2, 1922, that I last saw him alive on March 2, 1922, and that death occurred, on the date stated above, at 1:00 a.m.

The CAUSE OF DEATH\* was as follows:

Premature Birth  
(5 month foetus)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date ofWas there an autopsy? Yes

What test confirmed diagnosis?

(Signed) James B. Ryan, M. D.19 (Address) Mary Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

MAR 1922





D 61912

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61912

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2123 Washington* ST.: *12* WARD)2-FULL NAME *Rosie Batze* (BATZE)(a) RESIDENCE. NO. *2123 Washington* ST.: *12* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *10* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F*4 COLOR OR RACE *W.*5 Single, Married, Widowed, or Divorced (write the word) *married*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Randall G. Batze*

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*30**1**17*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore  
Maryland*10 NAME OF FATHER *Charles Elick*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Germany*12 MAIDEN NAME OF MOTHER *Rosie Smith*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Germany*

14

Informant  
(Address)*Randall G. Batze  
2123 Washington St.**1922*  
*1922**Robert P. Harrison*

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-2-22*

17

I HEREBY CERTIFY, That I attended deceased from  
*Feb 28*, 19*22*, to *March 2*, 19*22*that I last saw him alive on *March 2*, 19*22*and that death occurred, on the date stated above, at *2:15* p.m.

The CAUSE OF DEATH\* was as follows:

*meningitis  
(infection)*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)(duration) yrs. mos. ds. *10*18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Shepherd Dean*, M. D., 19 (Address) *1000 Columbia St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park**March 6 1922*

20 UNDERTAKER

ADDRESS

*George J. Smith**5000 W. Gay St.*

D 61913

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61913

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1344 Reynolds* ST. *10th* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Sophie Wieghebroka*(Residence in Baltimore: No. *1341 Reynolds* St.:yrs., *3* mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE

*white*

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

*Single*

## 6-DATE OF BIRTH,

*Nov. 6, 1911*  
(Month) (Day) (Year)

## 7-AGE,

*24* yrs. *24* mos. *24* ds. *less than 1 day,*  
..... yrs. .... mos. .... ds. .... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,  
(State or Country),*Baltimore*

## 10-NAME OF FATHER,

*Stanislaus Wojciechowski*

## 11-BIRTHPLACE OF FATHER

(State or Country),

*Poland*

## 12-MAIDEN NAME OF MOTHER

*Julia Boyard*

## 13-BIRTHPLACE OF MOTHER

(State or Country),

*Poland*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Stanislaus Wojciechowski*(Address) *1341 Reynolds St.*

## 15.

*Robert P. Harrison,*

Filed.....

191.....

Registrar.

3-1922

Serial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*3-2-1922*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*2-16-1922*, to *2-2-1922*,that I saw her alive on *3-1-1922*,and that death occurred, on the date stated above, at *9 P. m.*

The CAUSE OF DEATH\* was as follows:

*Broncho-pneumonia*

(Duration)..... yrs. .... mos. .... ds.

CONTRIBUTORY  
(Secondary)*Diarrhea & enteritis*

(Duration)..... yrs. .... mos. .... ds.

*Dr. P. W. M. D.**3-3-1922* (Address)..... *2202 W. North*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

*usual residence*

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Holy Rosary Church 1922*

## 20-UNDERTAKER

## ADDRESS

*John M. Weber 1803 Bank St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61914

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 W. Lanvale

ST.: 11 WARD)

2-FULL NAME Louis Gordon Dorsey

(a) RESIDENCE. NO. 124 W. Lanvale

ST.: WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. 3 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Martha Naylor

6 DATE OF BIRTH (month, day, and year) Nov. 23, 1869

7 AGE Years 52 Months 3 Days 9 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Theodore Dorsey

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Victoria Whitman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs. Martha Dorsey (Address) 124 W. Lanvale St.

15 Filled Robert P. Harrison, Registrar

3-1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1922, to Mar 2, 1922

that I last saw h.a.l.v. alive on Mar 2, 1922

and that death occurred, on the date stated above, at 7:40 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) Chronic Intestinal Prolaps (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? (Signed) J. S. Leonard, M. D.

, 19 (Address) 8 E. Eager St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Thomas' Cemetery, Garrison 3/4, 1922

20 UNDERTAKER Forest ADDRESS Henry W. Mears & Son 805 N. Calvert

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61915

## CERTIFICATE OF DEATH.

90 D 61915

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 148-Wilson-Street ST.: 14 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME GERMAN HORTON MEDINGER

(a) RESIDENCE. NO. 148-Wilson-Street ST. 14 WARD. (Resident)

(Usual place of abode)  
Length of residence in city or town where death occurred 68 yrs. 3 mos. 14 ds. How long in U. S., if of foreign birth? 68 yrs. 3 mos. 14 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Barron Medinger

6 DATE OF BIRTH (month, day, and year) Nov-16-1853

7 AGE Years 68 Months 3 Days 14 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired for the

(b) General nature of industry, business, or establishment in which employed (or employer) Contractg-Buildg Bus

(c) Name of employer (self)

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Geo. W. Medinger

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Geo. W. Medinger, (brother) (Address) 119-Mosher-St., City.

15 Filed Feb. 19 1922 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16 1922, to March 2 1922, that I last saw him alive on March 2 1922, and that death occurred, on the date stated above, at 12:5 P. M.

The CAUSE OF DEATH\* was as follows:

Chr. endo-carditis with much dilatation, and mitral insufficiency

CONTRIBUTORY (Secondary) Asthma and Exacerbation (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ☒ Date of ☒Was there an autopsy? ☒

What test confirmed diagnosis?

(Signed) Robert H. Mifflin M. D.

, 19 (Address) 1016 Madison St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

LOUDON PARK CEMETERY

Mar-7-22 19

20 UNDERTAKER

STEWART &amp; MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.

TION is very important. See instructions on back of certificates.

1922

Burial Permit Clerk.



D 61916

## HEALTH DEPARTMENT-CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

Single

6-DATE OF BIRTH

Jan 8<sup>th</sup>, 1922  
(Month) (Day) (Year)

7-AGE

1 yrs. 22 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Home

9-BIRTHPLACE  
(State or country)

Baltimore

10-NAME OF FATHER

James Bolimicki

11-BIRTHPLACE OF FATHER  
(State or country)

Poland

12-MAIDEN NAME OF MOTHER

Frances Zimboke

13-BIRTHPLACE OF MOTHER  
(State or country)

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Gertmar Bolimicki

(Address)

920 S. Ellwood Ave

15-

Robert P. Harrison,

1922 Burial Permit Clerk.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

March 3<sup>rd</sup>, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Feb. 28<sup>th</sup>, 1922, to March 3<sup>rd</sup>, 1922.that I saw him alive on Feb. 28<sup>th</sup>, 1922.

and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 10 ds.

Contributory  
(SECONDARY)

Specimen

(Duration) yrs. mos. 1 ds.

(Signed)

Jennie N. Browne

M. D.

March 3<sup>rd</sup>, 1922 (Address) 510 Park Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

St Stanislaus Cem

DATE OF BURIAL

Mar 6, 1922

20-UNDERTAKER

Stephen J. Fialkowski 1000 S. Kennerly

D 61917

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61917

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1314 Carey St. 21 WARD)

2-FULL NAME

Ernestina Maria Wiegand

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 1314 Carey

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single Married Widowed

or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Widowed

6 DATE OF BIRTH (month, day, and year)

Nov. 16 = 1839

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

82

3

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Wieland

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Frederick W. Burkman, Berwick, Pa.

4-1922

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3-3-1922

17

HEREBY CERTIFY, That I attended deceased from

1922 to 3-3-1922

that I last saw him live on 3-3-1922

and that death occurred, on the date stated above, at 8:10 a.m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Stephen D. Stein, M. D.

, 19 (Address)

1007 Calhoun St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cem

Mar 6 1922

20 UNDERTAKER

ADDRESS

Robert Burkman

HOLLINGS N 875

D 61918

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61918

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Baltimore

Registered No. C.....

City of BALTIMORE: (No. General Hospital. St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Matthew J. Rudolph.

39 -- 4 -- 19.

(Residence in Baltimore: No. 1213 Battery Ave St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, October 9th, 1882. (Month) (Day) (Year)

7-AGE, 39 yrs. 4 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Saloonkeeper. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore Md.

10-NAME OF FATHER, Matthew Rudolph.

11-BIRTHPLACE OF FATHER, (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Margaret -----.

13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida B. Rudolph. (wife).

(Address) 1213 Battery Ave.

15- Robert P. Harrison,

1922 Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 28th, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Fracture of the skull. Automobile accident.

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds. (Signed) M. D. (Coroner)

March 2, 1922. (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Accident. Light &amp; Montgomery sts.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Cathedral Cem. Mar. 4, 1922

20-UNDERTAKER, ADDRESS

W. J. G. Glynne 1412 Light St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61919

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 E Barney ST. 24 WARD)

## 2-FULL NAME

Dorothy Virginia Mitchell

## (a) RESIDENCE. NO. 123 E Barney

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 7 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Oct 23/21

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4

8

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

## 10 NAME OF FATHER

Wm Mitchell

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

## 12 MAIDEN NAME OF MOTHER

Carr Rottloff

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

## 14

Informant (Address)

Wm Mitchell 123 E Barney St

## 15

Robert P. Harrison

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 3 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Mar 1, 1922, to Mar 3, 1922,

that I last saw him alive on Mar 3, 1922,

and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia

(duration) yrs. mos. 7 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

15 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Wm Mitchell

M. D.

3/3, 1922 Address)

1319 High St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Wm Mitchell

Mar 4 1922

## 20 UNDERTAKER

## ADDRESS

Margaret G. Flynn

1319 High St

TION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

61920

D 61920

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard & Green ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Hudson Campbell

(a) RESIDENCE. No.

1327 Reynold

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of

Mrs Hudson Campbell

6 DATE OF BIRTH (month, day, year)

Unknown 1889

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

32

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

sterilizer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

John Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Mass.

12 MAIDEN NAME OF MOTHER

Rose King

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Mrs Hudson Campbell 1327 Reynold St.

15

Filed

19

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-2 1922

17

I HEREBY CERTIFY, That I attended deceased from

2-27 1922, to 3-2 1922

that I last saw him alive on 3-2 1922

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH\* was as follows:

Psy. Pneumonia thorax

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

fracture of larynx &amp; trachea following accidental taking of canthar

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Locum tenens

Did an operation precede death? No Date of 2/28/22

Was there an autopsy? No

What test confirmed diagnosis? physical signs

(Signed) R. B. Jones, M. D.

19 1922 Address) Union Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Cross A. A. Co. Cem

Mar. 6 1922

20 UNDERTAKER

ADDRESS

Margaret G. Flynn

1422 Light St.

D 61921 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61921

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Green &amp; Lombard

ST.

WARD)

2-FULL NAME

Ruthel Murray

(a) RESIDENCE, NO.

935 S. Howard St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

Colored

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 3, 21

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

9

29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md

10 NAME OF FATHER

Nathaniel Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Hilda Wesley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Hospital Records.

15

Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2, 19 22

17

I HEREBY CERTIFY, That I attended deceased from Feb 27, 19 22, to March 2, 19 22,

that I last saw him alive on March 2, 19 22,

and that death occurred, on the date stated above, at 6:27 p.m.

The CAUSE OF DEATH\* was as follows:

Miliary Tuberculosis.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death 935 S. Howard St.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Geo. E. Wells M. D.

, 19 (Address) Univ. Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn Ct

Mch 4 1922

20 UNDERTAKER

ADDRESS

J. H. Brown and Son

1800 Mt. Vernon

TION IS VERY IMPORTANT. See instructions on back of certificates.

4-1922

Serial Permit Clerk.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Lungs involved*  
*Meningitis & general*  
*tuberculosis*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61922

D 61922

1-PLACE OF DEATH

Union Memorial Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

510 Walnut Ave.

ST.: 16

WARD)

2-FULL NAME

Bessie Lowrey

(a) RESIDENCE. NO.

1626 Edmondson Ave

WARD.

Hillbills Ind.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. If of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single

6a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 1920

7 AGE

Years

Months

Days

If LESS than  
1 day, — hrs.  
or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Hillbills Ind.

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Edna Lowrey

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Maryland

PARENTS

14 Informant  
(Address)Edna Lowrey  
1626 Edmondson Ave

15

1922 Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

Dec 10, 1921, to Mar 3, 1922.

that I last saw her alive on Mar 3, 1922.

and that death occurred, on the date stated above, at 10:30 A. M.

The CAUSE OF DEATH\* was as follows:

Diffuse broncho-pneumonia.

(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY  
(Secondary)

malnutrition

(duration) — yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

clinical findings

(Signed)

Paul W. Sutter

M. D.

3/3, 1922 Address)

U. M. H.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Olive (Roshyn Ind)

Feb 5 1922

20 UNDERTAKER

ADDRESS

Josh Cook

1003 Hillbills

TION is very important. See instructions on back of certificate.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.  
[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior to pneumonia other than otitis media.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61923

## CERTIFICATE OF DEATH.

D 61923

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 S. Carlton ST. 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary C. Griffin(Residence in Baltimore: No. 19 S. Carlton St.; live yrs., 0 mos., 0 da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female4-COLOR OR RACE, Col5-SINGLE, Mar  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)6-DATE OF BIRTH, 1974

(Month)

(Day)

(Year)

7-AGE, 178yrs., 0 mos., 0 da.

If LESS than 1 day,

....hrs. or ....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work Laundry(b) General nature of industry, business, or establishment in which employed (or employer) 0419-BIRTHPLACE, (State or Country), Baltimore City10-NAME OF FATHER, Mr. Thomas11-BIRTHPLACE OF FATHER (State or Country), Mr. Thomas12-MAIDEN NAME OF MOTHER, Mr. Thomas13-BIRTHPLACE OF MOTHER (State or Country), Mr. Thomas

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) For Mitchell(Address) 129 N. Liberty

15-

Filed

4-1922

Robert P. Harrison,

Burial Permit Clerk, Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 1, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1, 1922 to March 1, 1922that I saw him alive on March 1, 1922and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH\* was as follows:

Exacerbated  
hemorrhage  
(Duration) 3 yrs., 0 mos., 0 da.CONTRIBUTORY (Secondary) Pulmonary disease(Duration) 4 yrs., 0 mos., 0 da.(Signed) Dr. J. H. Harrison M. D., 1922 (Address) 129 N. Liberty

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs., 0 mos., 0 da. In the State 0 yrs., 0 mos., 0 da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, MT AuburnDATE OF BURIAL, March 6, 192220-UNDERTAKER, David EastonADDRESS 816Pa Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61924

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 W. Lafayette Ave. ST. 17 WARD)

## 2-FULL NAME

## (a) RESIDENCE

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced (write the word)

Male Colored Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elvora Snowden

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 BIRTHPLACE OF FATHER (city or town) (State or country)

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14 Informant (Address)

## 15 Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

## 17 I HEREBY CERTIFY, That I attended deceased from

Dec. 24, 1921 March 3, 1922

that I last saw him alive on March 2, 1922

and that death occurred, on the date stated above, at 5:05 a.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia pulmonalis

## CONTRIBUTORY (Secondary)

Pneumonia intestinalis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. B. Robinson M.D.

(Address) 1520 Monument St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Catholic Bur.

## 20 UNDERTAKER

Daniel E. Evers

## DATE OF BURIAL

March 6, 1922

## ADDRESS

Be an

TION is very important. See instructions on back of certificates.

R4-1922

Burial Permit Clerk

D 61925 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61925

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. Veterans' Hospital #56

CITY OF BALTIMORE: (No. Ft. McHenry, Md.

ST. 16 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ERNEST GOOD

(a) RESIDENCE NO. U.S. Veterans' Hosp. #56-

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

35

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

U.S. Veterans' Hosp. #56

(c) Name of employer U.S. V. Hosp. #56, Balto. Md.

9 BIRTHPLACE (city or town) Virginia (State or country)

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14

Informant (Address)

EDGAR T. ROSENBROCK,

REGISTRAR, U.S. V. Hosp. #56

Baltimore, Md.

15

Robert P. Harrison,

Registrar

1922

Airial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1, 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb. 22, 1922, to March 1, 1922.

that I last saw him alive on March 1, 1922.

and that death occurred, on the date stated above, at 12:50 p.m.

The CAUSE OF DEATH\* was as follows:

Acute Suppurative Appendicitis

(duration) yrs. mos. ds.

Septicemia

CONTRIBUTORY (Secondary)

Feb. 23,

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Report

(Signed)

F. N. Gordon, M. D.

3/1/22 (Address) U.S. Veterans' Hosp. #56, Balto. Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Laurel Cemetery

DATE OF BURIAL

3/4, 1922

20 UNDERTAKER

S. Linsor &amp; Bro

ADDRESS

127 E. Baltos



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61926

## CERTIFICATE OF DEATH.

90 D 61926

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1805 N. Calvert* ST. *18* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Alexander W. Weems*

## (a) RESIDENCE. No.

*1805 N. Calvert*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed,

or Divorced (write the word)

*Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*1834*

## 7 AGE

Years

Months

Days

If LESS than  
1 day. hrs.  
or min.*83*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Retired*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)*Bedding Manuf.*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore Md.*

## 10 NAME OF FATHER

*John W. Weems*

## 11 BIRTHPLACE OF FATHER (city or town)

*Maryland*

## 12 MAIDEN NAME OF MOTHER

*Martha P. Williams*

## 13 BIRTHPLACE OF MOTHER (city or town)

*Maryland*

## 14

Informant  
(Address)*John W. Weems.  
1805 N. Calvert St.*

## 15

Filed

19

*Robert F. Harrison, Registrar*

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*3/3 1922*17 I HEREBY CERTIFY, That I attended deceased from  
*from time to time for several years*  
*but not very recently* 19that I last saw him alive on *Feb 27* 1922and that death occurred, on the date stated above, at *9 a* m.

The CAUSE OF DEATH\* was as follows:

*Acute heart dilatation  
few moments*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)*Myocarditis, acute,  
(duration) *many* yrs. mos. ds.*18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *History*(Signed) *W. B. Harrison* M. D., 19 (Address) *1008 Cathedral*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Lorraine Cem**3-6 1922*

## 20 UNDERTAKER

*Henry J. Harrison & Sons Co*

## ADDRESS

*W. B. Harrison*

CAUSE OF DEATH IN plain terms, so that it may be properly understood. See instructions on back of certificates.

R4

D 61927.

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 61927

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 N. Port ST., 6 WARD)

## 2. FULL NAME

(a) RESIDENCE NO. 223 N. Port

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 41 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julius Williams

6 DATE OF BIRTH (month, day, and year) June 28-1884

7 AGE Years 67 Months 8 Days 26 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Christian Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Bonnie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Martha Goth (Address) 223 N. Port

15 -1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-2-1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1922, to 3-2-1922, that I last saw him alive on 3-2-1922, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH\* was as follows:

Acute Regurgitation  
Ventricles of hypertensum  
Anemia

CONTRIBUTORY acute Edema of lungs (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? finding

(Signed) M. D.

(Address) 100 N. Pratt St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL DATE OF BURIAL

Oak Lawn Cemetery March 6, 1922

20 UNDERTAKER ADDRESS

Mrs. L. Miller 233 N. Pratt St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61928

## CERTIFICATE OF DEATH.

31 D 61928

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2409 E Monument T. 7 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry E Simpson(a) RESIDENCE NO. 2409 E Monument ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofLouisa Simpson6 DATE OF BIRTH (month, day, and year) Jan 29-18727 AGE 50 Years Months — Days 28 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telephone Operator

(b) General nature of industry business, or establishment in which employed (or employer)

(c) Name of employer Polia Dept9 BIRTHPLACE (city or town) Maryland  
(State or country)10 NAME OF FATHER Charles Simpson11 BIRTHPLACE OF FATHER (city or town) Maryland  
(State or country)12 MAIDEN NAME OF MOTHER Anna Baan13 BIRTHPLACE OF MOTHER (city or town) Maryland  
(State or country)14 Informant Louisa Simpson  
(Address) 2409 E Monument St15 Robert P. Harrison,  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28<sup>th</sup> 192217 I HEREBY CERTIFY, That I attended deceased from Nov 8<sup>th</sup>, 1921, to Feb 28, 1922.that I last saw him alive on Feb 25<sup>th</sup>, 1922.and that death occurred, on the date stated above, at P. m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis Pulmonalis(duration) 1 yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Lloyd M. D., 19 (Address) 1927 E. Monument St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER Baltimore Cemetery March 4 1922  
Ans C. Miller ADDRESS 2334 Jeffers

TION is very important. See instructions on back of certificate.

4

- 1922

Burial Permit Clerk.

D 61929

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 D 61929

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Little Sisters of the Poor* 10 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *E. Elizabeth Butler*(a) RESIDENCE. NO. *Preston Valley Dr.* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widow of*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Fredrick Q. Butler*6 DATE OF BIRTH (month, day, and year) *30 Aug. 1849*7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*72* *7* *11*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Lissberg*  
(State or country) *Germany -*10 NAME OF FATHER *George Martin*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)12 MAIDEN NAME OF MOTHER *Barbara Himmel*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)14 Informant *Sister Florence, Supr.*  
(Address) *Little Sisters of the Poor*15 Filed *Robt. P. Harrison*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 3* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *to second* to 19that I last saw him alive on *March 1*, 19*22*.and that death occurred, on the date stated above, at *12.30 P.m.*

The CAUSE OF DEATH\* was as follows:

*Valvular disease of heart**Unknown* (duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? *Albany, N.Y.*(Signed) *Mon* 19 (Address) *1133 Valley St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Cathedral* *Mar 4* 19*22*

20 UNDERTAKER ADDRESS

*H. C. Windefield* *914 Greenock Ave*

TION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61930

D 61930

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 535 Lee St. ST. 22 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME Elizabeth McKenney

(a) RESIDENCE. No. 535 Lee St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Widowed &amp; J. McKenney

6 DATE OF BIRTH (month, day, and year) Jan 26 1838

7 AGE

84

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

New York

10 NAME OF FATHER

Chas. Page

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant  
(Address)Cida McKenney  
535 Lee St.

15

F. B. Harrison, Registrar

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 28, 1922, to Mar 2, 1922

that I last saw him alive on Mar 1, 1922

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:

Congestion of the Lungs  
(duration) yrs. mos. 3 ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyal, M. D.

34, 1922 (Address) 602 Columbia

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park Cemetery

DATE OF BURIAL

March 4 1922

20 UNDERTAKER

Geo. Leimbach &amp; Son

ADDRESS

647 N. Broadway

R4-1922

Special Permit (Clark)

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Chronic valvular  
heart disease. No  
pneumonia.*

D 61931

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61931

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Memorial Hospital*)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mr. Sol A. Levy*(a) RESIDENCE. NO. *1919 Eastern*

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

8 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Martha Greenbaum Levy*

6 DATE OF BIRTH (month, day, and year)

*May 16, 1866*

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*56**9**15*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Salesman*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*New York*

10 NAME OF FATHER

*Bernard Levy*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Pauline Nathan*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*

14

Informant (Address)

*Wife - same address*

15

File - 1922 Robert P. Hart (1866)

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 3 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*March 1st, 1922, to March 3, 1922,*that I last saw him alive on *March 3, 1922,*and that death occurred, on the date stated above, at *11:00 a.m.*

The CAUSE OF DEATH\* was as follows:

*Central pneumonia ?*

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Gordon S. Seagraves, M.D.*3-3, 1922 (Address) *Union Mem. Hosp. Baltimore*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Balts Hebrew* *hid. 5 1922*

20 UNDERTAKER

ADDRESS

*Gund Sondheim* *1184 Oak St.*

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

No accident Septicaemia  
due to pneumonia.  
No further history



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61932

## CERTIFICATE OF DEATH.

90 D 61932

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 7 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Felix Calan

## (a) RESIDENCE. NO.

Hebrew Hospital & Asylum ST.,

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Isabelle Calan6 DATE OF BIRTH (month, day, and year) Jan 12/19377 AGE Years 84 Months 8 Days 18 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired OK

(b) General nature of industry, business, or establishment in which employed (or employer)

Hotel

(c) Name of employer

Miller

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Isaac

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Isaac

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany14 Informant Hospital Records (Address)15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/2/22 1917 I HEREBY CERTIFY, That I attended deceased from 2/28/22, 1922, to 3/2/22, 1922, that I last saw him alive on 3/2/22, 1922.and that death occurred, on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH\* was as follows:

Cerebral Embolus

(duration) yrs. mos. ds.

CONTRIBUTORY Chronic Myocarditis (Secondary)(duration) 4 yrs. mos. ds.

18 Where was disease contracted

If not at place of death? XDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edgar M. D.3/2/22, 1922 Address Hebrew Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Chel Shalom Mar 5 1922

20 UNDERTAKER ADDRESS

David S. S. S. 400 N. B. St.

D 61933

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61933

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 W. Saratoga ST.: 4 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. 505 W. Saratoga ST.

(Usual place of abode)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

WARD.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE col 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown, 1872

7 AGE Years Months Days If LESS than 1 day. hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14 Informant (Address)

15 Filed

1922

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2 1922

17 I HEREBY CERTIFY, That I attended, deceased from March 1, 1922, to March 2, 1922, that I last saw him alive on March 1st 1922, and that death occurred, on the date stated above, at 2 P. M. The CAUSE OF DEATH\* was as follows: on March 2, 1922

Lobar Pneumonia  
seen once only.  
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. B. Evans M. D.

19 (Address) 411 W. Greene St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Spec. 6-12-17 H. P. Co.—1000 Bks.  
D 61934

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

320 61934

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1729 N. Bradford ST.

WARD) 8

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Lillian Ruth Finch

## (a) RESIDENCE. NO.

1729 N. Bradford

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

13 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Jan. 24 1909

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

13

1

6

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Balto Md.

## 10 NAME OF FATHER

John H Finch

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Balto Md

## 12 MAIDEN NAME OF MOTHER

Conie Bender

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Balto Md.

## 14

Informant  
(Address)John H Finch (Father)  
1729 N Bradford St

## 15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 2nd 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb 21st 1922, to March 2nd 1922

that I last saw her alive on March 2nd 1922

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH\* was as follows:

Tubercular Meningitis

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY  
(Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted  
if not at place of death?

at place of death

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis? Physical Findings &amp; Lab. Test

(Signed) Harry Heibel M. D.

5/2, 1922 (Address) 1224 Hanover St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Cedar Hill

3-4 1922

## 20 UNDERTAKER

## ADDRESS

E &amp; B Harle

115 E N 2nd St

D 61935

HEALTH DEPARTMENT—CITY OF BALTIMORE

61935

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1282 Battery AveST. 24<sup>th</sup> WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Regina Besche(a) RESIDENCE. NO. 1282 Battery AveST. 24<sup>th</sup> WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred about 50 yrs. yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced (write the word) Widow6a ~~Married~~ Widowed, or ~~divorced~~ WIFE of Joseph Besche6 DATE OF BIRTH (month, day, and year) April 30 1848

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 73 10 1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none(b) General nature of industry, business, or establishment in which employed (or employer) —(c) Name of employer —9 BIRTHPLACE (city or town) (State or country) Germany10 NAME OF FATHER Henry Sommer11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Luna C Wagner13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany14 Informant Chas. Besche (Son)(Address) 1282 Battery Ave15 1922 Robert P. Harrison,

Burial Permit Clerk. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 3<sup>rd</sup> 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan, 1922, to Mch 3, 1922.That I last saw her alive on Mch 2, 1922.and that death occurred, on the date stated above, at 12<sup>15</sup> A. m.

The CAUSE OF DEATH\* was as follows:

Spleno-myelogenous leukaemia(duration) 3 yrs. mos. ds.CONTRIBUTORY (Secondary) Asthma

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? ✓Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Usual(Signed) E. N. Hayward, M. D.3/3 1922 (Address) 23 W. ...

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Cross A.C.C.3-6 1922

20 UNDERTAKER

ADDRESS

Er B Harle115 E. ...

TION is very important. See instructions on back of certificates.



D 61936 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1373 Calhoun ST., 15 WARD)

## 2-FULL NAME

Earl Hubbard

## (a) RESIDENCE NO.

1373 Calhoun St.

(Usual place of abode)

Length of residence in city or town where death occurred

1 yrs. 6 mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced, (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

6

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

John B. Hubbard

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Mrs. Bennett

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

PARENTS

14 Informant (Address)

Earl Hubbard, 1373 Calhoun St.

15

Robert P. Harrison,

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 25, 1922, to March 2, 1922

that I last saw him alive on March 2, 1922

and that death occurred, on the date stated above, at Mar. 3, 29m.

The CAUSE OF DEATH\* was as follows:

Pneumonia (Bronchis)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Caroline Towles, M. D.

19 (Address) 1608 Park Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Manner and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

NOVA

20 UNDERTAKER

ADDRESS 1300

CAUSE OF DEATH is very important. See instructions on back of certificates.

RD - 1922

Serial Permit Clerk

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61937

## CERTIFICATE OF DEATH.

D 61937

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 4 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Kellam(a) RESIDENCE. NO. 639 Vine St ST. 4 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 1/2 yrs. mos. ds.

How long in U. S., If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18617 AGE 30 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia10 NAME OF FATHER Albert Kellam

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia14 Informant Hospital Records. (Address) Municipal Hospital.15 Filed MAR 4 - 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 192217 I HEREBY CERTIFY, That I attended deceased from February 21 1922, to March 2 1922, that I last saw her alive on March 1 1922, and that death occurred, on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH\* was as follows:

Periculous Anemia(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 1/2Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clayde McNeill M. D.3/2/1922 Address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Int. Auburn

ADDRESS

20 UNDERTAKER

R. G. Gross 1425 McElderry

CAUSE OF DEATH in plain terms, so that it may be properly transcribed on back of certificate. See instructions on back of certificates.

D 61938

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61938

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3601 E Lombard ST. 76 WARD)

## 2. FULL NAME

John G Miller

## (a) RESIDENCE NO.

3601 E Lombard ST. 76 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

68 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 192217 I HEREBY CERTIFY, That I attended deceased from 2/26/22, 1922 to 3/1/22, 1922, that I last saw him on 3/1/22, 1922, and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH\* was as follows:

Cerebral thrombosisCONTRIBUTORY (Secondary) acute myocarditis (duration) 1 yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) D. J. Harrison, M. D.(Address) 7919 E. Baltimore

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married5a Married, widowed, or divorced HUSBAND of (or) WIFE ofBarbara Miller

6 DATE OF BIRTH (month, day, and year)

Feb 16 - 1882

7 AGE

Years

Months

Days

7014

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Conrad Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Barbara Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Barbara Miller3601 E. Lombard

15

Robert P. Harrison,

, 19

Registrar

R4-1922

Partial Permit Clerk.

CAUSE OF DEATH is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61939

D 61939

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1635 Miller

ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Frousek

(a) RESIDENCE NO. 1635 Miller

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 00 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of John F. Frousek (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't know

7 AGE 74 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Austria (State or country)

10 NAME OF FATHER Lushack

11 BIRTHPLACE OF FATHER (city or town) Austria (State or country)

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) Austria (State or country)

14

Informant (Address)

Mrs. H. Clifton Deal 1635 Miller Robert F. Harrison,

15

1922

Burial Permit Clerk Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1922

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1922 to March 2, 1922 that I last saw him alive on March 2, 1922

and that death occurred, on the date stated above, at 10:30 p. m. The CAUSE OF DEATH\* was as follows:

Bronchitis

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. J. Bagh M. D.

19 (Address) 719 N. B. Lacey

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER John Kerwig V. C.

DATE OF BURIAL

March 1922

ADDRESS

2038 Belman

See instructions on back of certificates.



**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No chronic organic trouble  
Chronic bronchitis. Not  
capillary.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61940

D 61940

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 6 WARD)2-FULL NAME Charles Tube(a) RESIDENCE. NO. 137 N. Bradford St. ST.: 6 WARD. (If nonresident give city or town and State)  
(Usual place of abode)  
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 1848 Aug 21  
7 AGE Years 73 Months --6 Days --3 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown14 Informant Hospital Records,  
(Address) Municipal Hospital15 Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3, 192217 I HEREBY CERTIFY, That I attended deceased from January 5, 1922 to March 3, 1922, that I last saw him alive on March 2, 1922, and that death occurred, on the date stated above, at 11:07 A.M.  
The CAUSE OF DEATH was as follows:Pneumonia(duration) yrs. mos. 5 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. M. M. D.3/3/1922 (Address) Municipal Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

AR 4 - 1922

Burial Permit (1922)

D 61941 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61941

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home - Infirmary

REGISTERED NO.  
(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

CITY OF BALTIMORE: (No. 6 ST. 6 WARD)

2-FULL NAME Mr. Samuel Green

(a) RESIDENCE NO. 3335 A. St. Philadelphia ST. 6 WARD Philadelphia Pa.  
(Usual place of abode) about 1 month with care (If non-resident give city or town and State)  
Length of residence in city or town where death occurred 0 mos. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a Married, widowed, or divorced  
HUSBAND of6 DATE OF BIRTH (month, day, and year) Oct 3<sup>rd</sup> 1868

7 AGE Years 53 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 146  
(b) General nature of industry, business, or establishment in which employed (or employer) Textile weaver  
(c) Name of employer9 BIRTHPLACE (city or town) Island  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Unknown  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)14 Informant Records of Church Home  
(Address) Keith B. Rice

15 Robert P. Harrison, 19 1922 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1922

17 I HEREBY CERTIFY, That I attended deceased from 8.30 a.m. 1922 to March 4, 1922.

that I last saw him alive on March 4, 1922.

and that death occurred, on the date stated above, at 6.15 p.m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Rectum -  
(Keith B. Rice) 6 months  
March 15, 1922 (duration) 12 mos.CONTRIBUTORY Intestinal Obstruction  
(Secondary) (duration) yrs. mos. 10 ds.18 Where was disease contracted ( ? )  
if not at place of death?

Did an operation precede death? Yes Date of Feb 22 1922

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Keith B. Rice - M. D.

19 (Address) Church Home - Infirmary

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL DATE OF BURIAL

Philadelphia Pa 3-4-1922

20 UNDERTAKER J. J. Moran ADDRESS 300 E. Baltimore

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61942

## CERTIFICATE OF DEATH.

D 61942

## 1. PLACE OF DEATH

CITY OF BALTIMORE; (No. *1903 N. Fulton St.* ST. *15* WARD)

## 2. FULL NAME

(a) RESIDENCE NO. *1903 N. Fulton St.* ST. *15* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *60* yrs. mos. ds.How long in U. S., if of foreign birth? *60* yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Abraham Goldensky*

6 DATE OF BIRTH (month, day, and year)

*Mar 20/1894*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*77**11**12*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

1922

Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb 4<sup>th</sup> 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*March 1, 1922, to March 7, 1922.*that I last saw her alive on *March 3, 1922,*and that death occurred, on the date stated above, at *3:40 a. m.*

The CAUSE OF DEATH\* was as follows:

*Heart and renal insufficiency*(duration) *1* yrs. mos. ds.

CONTRIBUTORY (Secondary)

*and failure of heart* (duration) *3* yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physical exam.*(Signed) *C. Urban Smith* M. D., 19 (Address) *877 Park Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MORTAL

20 UNDERTAKER

DATE OF BURIAL

*Balt Hebrew**Mar 6<sup>th</sup> 1922**David Soudheim*

ADDRESS

*40 W. 11th St. N.Y.C.*



D 61943 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61943

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Union Memorial Hospital* REGISTERED NO. *131*  
 CITY OF BALTIMORE: (No. *1514* *Division St.* ST.: *14* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
 2-FULL NAME *Miss Mary Siedt*  
 (a) RESIDENCE, NO. *370 72<sup>nd</sup> St* ST.: *Brooklyn, N.Y.* WARD. *Brooklyn, N.Y.*  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. *18* How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*  
 5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Feb 23 1867*

6 DATE OF BIRTH (month, day, and year)  
 7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*55 11 9*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Unknown*  
 (b) General nature of industry, business, or establishment in which employed (or employer) *087*  
 (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Brooklyn, N.Y.*

10 NAME OF FATHER *Charles Siedt*  
 11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*  
 12 MAIDEN NAME OF MOTHER *Doris Trient*  
 13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14 Informant *Henry Eise*  
 (Address) *125 24<sup>th</sup> Ave City*

15 Filled *Robert P. Harrison,* Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3 3 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Feb. 14*, 19*22*, to *March 3*, 19*22*, that I last saw her alive on *March 3*, 19*22*, and that death occurred, on the date stated above, at *1:30 P.M.*

The CAUSE OF DEATH\* was as follows:

*myocardial insufficiency*

(duration) yrs. mos. *7* ds.  
 CONTRIBUTORY *not operative Pneumonia*  
 (Secondary) (duration) yrs. mos. *1* ds.

18 Where was disease contracted? *?*  
 If not at place of death?

Did an operation precede death? *Yes* Date of *Feb. 25, 22*

Was there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Paul W. Sullivan, M.D.*

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Brooklyn N.Y. Mar 6 1922*

20 UNDERTAKER ADDRESS

*Josiah Syfer 1600 W North*

See instructions on back of certificates.

1922

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Operation for  
Cyst lower end left  
Kidney. Resection  
of kidney. Cause  
of duration unknown.*

D 61944

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61944

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 315 N. Bruce ST.: 19 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lottie Seger

(a) RESIDENCE, NO. 315 N. Bruce ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female Color Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest Seger

6 DATE OF BIRTH (month, day, and year) Dec 10, 1887

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

54 2 22

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Kept own home

9 BIRTHPLACE (city or town) Essex Co., Va. (State or country)

10 NAME OF FATHER Louis Corbin

11 BIRTHPLACE OF FATHER (city or town) Essex Co., Va. (State or country)

12 MAIDEN NAME OF MOTHER Amanda Blue

13 BIRTHPLACE OF MOTHER (city or town) Essex Co., Va. (State or country)

14 Informant Fannie Smith (Address) 315 N. Bruce

15 MAR 5 - 1922

ROBERT H. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1922, to March 2, 1922

that I last saw her alive on March 1, 1922

and that death occurred, on the date stated above, at 1.05 P. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma Right Breast (duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY Bronchitis Chronic (Secondary) (duration) 3 yrs. 3 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W. H. Wright M. D.

(Address) 1209 Prosser St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Laurel Cemetery 3/5/22

20 UNDERTAKER ADDRESS

J. B. Rye 102 E Mulberry St

D 61945 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2802-Allendale-Av.

ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Cowlam Wedeman

(a) RESIDENCE. NO. 2802-Allendale-Av.

ST. 15 WARD. (Resident)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 8 mos. ? ds. How long in U. S., if of foreign birth? 2 yrs. 11 mos. 19 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

March-14-1919.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
2	11	19		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

None

9 BIRTHPLACE (city or town)  
(State or country)Schnectady  
New York

10 NAME OF FATHER Wayne Wedeman

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Jermyn  
Penna

12 MAIDEN NAME OF MOTHER Sara Cowlam

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Troll  
England

14 Informant Wayne Wedeman (father)

(Address) 2802-Allendale-Av., City

15 FILED MAR 5 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 5 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb. 22, 1922, to March 5, 1922,

that I last saw her alive on March 5, 1922,

and that death occurred, on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH\* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY  
(Secondary)Keypoints  
(duration) yrs. mos. 1 ds.18 Where was disease contracted  
if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Chemistry.

(Signed) Fred Smith, M. D.

3/8, 1922 (Address) 11 Elbow St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

SCHNECTADY, New York.

MAR-5-22<sup>19</sup>20 UNDERTAKER  
STEWART & MOWEN COMPANY  
WILLIAM F. WOODEN, Successor

ADDRESS

108 W. NORTH AVE.

TION is very important. See instructions on back of certificates.



D 61946

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

61946

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

675 W. Fayette

ST.:

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Infant of Julius &amp; Rosa Jacobson

## (a) RESIDENCE. NO.

675 W. Fayette

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

white

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than  
1 day, 7 hrs.  
or min.

This

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

11

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Balto. Md

## 10 NAME OF FATHER

Julius Jacobson

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Russia

## 12 MAIDEN NAME OF MOTHER

Rosa Kroop

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Russia

## 14

Informant  
(Address)Julius Jacobson  
675 W. Fayette St

## 15

Filed

MAR 5 - 1922

ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 4 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Mar. 4, 1922, to Mar. 4, 1922

that I last saw him alive on Mar. 4, 1922

and that death occurred, on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH\* was as follows:

Prematurity (26 wks.)

(duration) yrs. mos. ds. 7 hrs.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Wm B Schapers, M. D.

, 19 (Address) 2350 Eutaw Place

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Abnaw Posedale

## DATE OF BURIAL

3/5 1922

## 20 UNDERTAKER

J. Linsion &amp; Bro E. Balto St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61947

D 61947

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1250 Glynclon*)ST. *71* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Harry E. Dorsey.*(a) RESIDENCE NO. *1250 Glynclon* ST. \_\_\_\_\_ WARD \_\_\_\_\_  
(Usual place of abode) (If non-resident give city or town and State)Length of residence in city or town where death occurred *Life* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_  
How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) \_\_\_\_\_5a If married, widowed, or divorced  
HUSBAND of \_\_\_\_\_  
(or) WIFE of \_\_\_\_\_6 DATE OF BIRTH (month, day, and year) *Dec. 20 1919*7 AGE Years *2* Months *2* Days *14* If LESS than 1 day, hrs. \_\_\_\_\_ or min. \_\_\_\_\_

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *At home*

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) (State or country) *Baltimore Md.*10 NAME OF FATHER *Lawrence Dorsey*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore Md.*12 MAIDEN NAME OF MOTHER *Mary Willhite*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore Md.*14 Informant *Lawrence Dorsey.*  
(Address) *1250 Glynclon Ave.*15 **MAR 5 - 1922** ROBERT R. KRAUTER,  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 4 1922*17 I HEREBY CERTIFY, That I attended deceased from *Mar 3*, 19*22*, to *Mar 4*, 19*22*, that I last saw him alive on *Mar 4*, 19*22*, and that death occurred, on the date stated above, at *7:30 A.M.*

The CAUSE OF DEATH\* was as follows:

*Laryngeal Diphtheria*(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. *1* ds.

CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. *1* ds.

18 Where was disease contracted if not at place of death? \_\_\_\_\_

Did an operation precede death? *No* Date of \_\_\_\_\_Was there an autopsy? *No*What test confirmed diagnosis? *Clinical*  
(Signed) *R. F. Campbell*, M. D.  
*Mar 4 1922* (Address) *1644 Humes St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*London Park Cemetery* *Mar 5 1922*  
20 UNDERTAKER ADDRESS*H. Sanders & Sons* *1710 E. Baltimore*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

D 61948

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61948

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *Franklin St. Hospital* ST. *25* WARD)

REGISTERED NO. C

## 2-FULL NAME

(Residence in Baltimore: No. *232* *Westport* yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>Female</i>	4-COLOR OR RACE. <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <i>Married</i> (Write the word.)
6-DATE OF BIRTH. <i>July</i> <i>18</i> , <i>1869</i> . (Month) (Day) (Year)		
7-AGE. <i>52</i> yrs. <i>7</i> mos. <i>15</i> ds.		If LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>Housewife</i> (b) General nature of industry, business, or establishment in which employed (or employer). <i>23</i>		

9-BIRTHPLACE,  
(State or Country), *Baltimore, Md.*

PARENTS.	10-NAME OF FATHER, <i>Thomas A. Link</i>
	11-BIRTHPLACE OF FATHER (State or Country), <i>Baltimore, Md.</i>
	12-MAIDEN NAME OF MOTHER <i>Emma Culet</i>
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Baltimore, Md.</i>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Joseph A. Bay*(Address) *232 Westport St.*

15-

MAR 5 - 1922

ROBERT B. KRAUTER,

Registrar.  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Mar* *3*, *1922*.  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Feb 27* 1922, to *Mar 3* 1922, that I saw him alive on *Mar 3* 1922, and that death occurred, on the date stated above, at *2:37* a.m.

The CAUSE OF DEATH\* was as follows:

*Acute Cholecystitis*  
*Pancreatitis*  
(Duration) ... yrs. ... mos. ... ds.CONTRIBUTORY (Secondary) *Pulmonary Embolism*(Signed) *Walter J. Parr* M. D.  
*3131*, 1922 (Address) *Franklin St. Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

*London Park Cemetery* *Mar. 6*, 1922.

20-UNDERTAKER

*H. Hander & Sons* *170 E. 6th St.*

# Cholelithiasis. Confirmed by operation.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

*lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septichæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

<i>Abortion,</i>	<i>Cellulitis,</i>	<i>Childbirth,</i>	<i>Convulsions,</i>
<i>Hæmorrhage,</i>	<i>Gastritis,</i>	<i>Erysipelas,</i>	<i>Meningitis,</i>
<i>Gangrene,</i>	<i>Miscarriage,</i>	<i>Necrosis,</i>	<i>Peritonitis,</i>
<i>Phlebitis,</i>	<i>Pyæmia,</i>	<i>Septicæmia,</i>	<i>Tetanus.</i>

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.



## HEALTH DEPARTMENT—CITY OF BALTIMORE 002

D 61949

## CERTIFICATE OF DEATH.

94-D 61949

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hehren Name full name* ST., WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Jacob Rosenheim*(a) RESIDENCE NO. *2100 E Balto St* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred *life* yrs. mos. ds.How long in U. S., if of foreign birth? *life* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*white*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *June 12 - 1852*

7 AGE

*69*

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balt City Md*10 NAME OF FATHER *Goetz Rosenheim*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balt Md*12 MAIDEN NAME OF MOTHER *Elina*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balt*

14

Informant (Address) *Jack Lewis 1439 E Balto St*

15

MAR 5 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/3* 19*22*

17

I HEREBY CERTIFY That I attended deceased from *March 2, 1922* to *March 3, 1922*.that I last saw him alive on *March 3, 1922*and that death occurred, on the date stated above, at *4:30 P. M.*

The CAUSE OF DEATH\* was as follows:

*Ac Cordiocarditis over*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *bronchitis, Emphysema*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *clinical*(Signed) *W. J. Baughman*, M. D.3/4, 1922 (Address) *140 H. Street*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-BURIAL

DATE OF BURIAL

*Hehren Freindschulen* *5/5* 1922

UNDERTAKER

ADDRESS

*Jack Lewis 1439 E Balto St**5 Balto St*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Chronic bronchitis. No pneumonia. Not tubercular.*  
*No chronic valvular lesion.*  
*Dilated heart.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61950

D 61950

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

St Agnes Hosp.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.: 3 WARD)

2-FULL NAME

Benjamin Wolfson

(a) RESIDENCE. NO.

1519 East Pratt

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

30 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

Wh (Russian)

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Annie Wolfson

6 DATE OF BIRTH (month, day, and year)

1852

7 AGE

70

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Grocer -

034

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Heur's 1439 E. Baltimore St.

15

MAR 5 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3-5-1922

17

I HEREBY CERTIFY, That I attended deceased from

2-12-1922, to 3-5-1922,

that I last saw him alive on 3-5-22, 19

and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH was as follows:

Intestinal Obstruction and Peritonitis -

CONTRIBUTORY (Secondary)

(duration) several days - yrs. mos. ds.

Cough &amp; fainting - yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? yes Date of 2-12-22

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) W. C. Caldwell, M. D.

, 19 (Address) St. Agnes Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

North Point &amp; Germantown 3/5 1922

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E. Baltimore St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61951

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Friendly Am. Syn. 5* WARD)

## 2. FULL NAME

*Israel Kepner*

## (a) RESIDENCE NO.

*115 Aisquith St*

(Usual place of abode)

Length of residence in city or town where death occurred *35* yrs. mos. ds.

ST.

WARD

(If non-resident, give city or town and State)

How long in U. S., if of foreign birth? *35* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*white*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*widow*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Unknown*

## 6 DATE OF BIRTH (month, day, and year)

*Unknown*

## 7 AGE

*82*

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

*Unknown*

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Russia*

## 10 NAME OF FATHER

*Unknown*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Russia*

## 12 MAIDEN NAME OF MOTHER

*Unknown*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Russia*

## 14

Informant (Address)

*Heavis 1411 E. B. 1st*

## 15

MAR 5 - 1922

ROBERT R. KRAUTER, Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*3/4 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from *March 1, 1922*, to *March 4, 1922*.that I last saw him alive on *March 4, 1922*.and that death occurred, on the date stated above, at *10 P. m.*

The CAUSE OF DEATH\* was as follows:

*Myocarditis*

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical*

(Signed)

3/5/22 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

*Hebrew Mt. Carmel**2-5 1922**Jack Lewis, 1438 E. B. 1st*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61952

D 61952

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 N Lakewood ST., 7 WARD)

## 2. FULL NAME

Ruth Seiland Westley

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 720 N Lakewood ST., 7 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 7 mos. 10 ds. How long in U. S., if of foreign birth? 4 yrs. 7 mos. 10 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 15 - 19187 AGE Years 4 Months 11 Days 18 If LESS than 1 day, 1 hrs. 10 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore10 NAME OF FATHER Dr. J. H. Westley11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore12 MAIDEN NAME OF MOTHER Carrie Seiland13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

## 14

Informant Carrie Westley  
(Address) 720 N Lakewood

MAR 5 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5 1922

17

I HEREBY CERTIFY, That I attended deceased from July 26, 1922, to March 5, 1922, that I last saw her alive on March 4, 1922,and that death occurred, on the date stated above, at 1 2 m.

The CAUSE OF DEATH\* was as follows:

Septicemia

CONTRIBUTORY (Secondary)

(duration) 7 mos. 3 da.18 Where was disease contracted If not at place of death? not knownDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Inspiration & C(Signed) Adolph C. Eisenberg, M. D.1922 (Address) 2201-03 Orleans St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Oak Lawn Cem

20 UNDERTAKER

J. Herwig & Co

DATE OF BURIAL

Mar 5 1922

ADDRESS

2201-03 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 61953

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61953

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *19 Rosemont Ave.* WARD *2*)2-FULL NAME *Barbara Getz*(a) RESIDENCE NO. *19 Rosemont* ST. *2* WARD *2*

(Usual place of abode)

Length of residence in city or town where death occurred *70* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *late John Getz*6 DATE OF BIRTH (month, day, and year) *July 1830*7 AGE Years *91* Months *8* Days *1* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *John Metzger*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Dora Knowlton*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*14 Informant *Mr. Charles Talbot* (Address) *19 Rosemont Ave.*15 *MAR 5 - 1922* ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 3* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *Jan 6*, 1922, to *March 3*, 1922, that I last saw him alive on *March 2*, 1922,and that death occurred, on the date stated above, at *7 P.* m.

The CAUSE OF DEATH\* was as follows:

*Stroke*

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *John Lloyd* M. D.19 (Address) *1932 Rosemont St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Holy Redeemer**Mar 6* 19*22*20 UNDERTAKER *Robt. Turner*ADDRESS *1441**4 Broadway*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61954

D 61954

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *245 N Arlington Ave* 18 WARD)2. FULL NAME *Wm. G. Cooper*(a) RESIDENCE NO. *254 N Arlington Ave* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred *40* yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*4. COLOR OR RACE *Colored*5. Single, Married, Widowed, or Divorced, (write the word) *Married*

5a. If married, widowed, or divorced

HUSBAND of *Bertha Cooper*  
(or) WIFE of6. DATE OF BIRTH (month, day, and year) *Dec 17, 1868*

7. AGE

Years *53*Months *2*Days *12*If LESS than  
1 day, hrs.  
or min.

## 8. OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer*(b) General nature of industry, business, or establishment in which employed (or employer) *Paper factory*

(c) Name of employer

9. BIRTHPLACE (city or town) *Williamsport Md*  
(State or country)10. NAME OF FATHER *Unknown*11. BIRTHPLACE OF FATHER (city or town) *Unknown*  
(State or country)12. MAIDEN NAME OF MOTHER *Unknown*13. BIRTHPLACE OF MOTHER (city or town) *Unknown*  
(State or country)

14.

Informant *Bertha Cooper*  
(Address) *245 N Arlington Ave*

15.

MAR 5 - 1922

ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year) *March 2, 1922*17. I HEREBY CERTIFY, That I attended deceased from *Sept 11, 1921* to *March 2, 1922*  
that I last saw him alive on *Feb 28, 1922*,  
and that death occurred, on the date stated above, at *1 p. m.*  
The CAUSE OF DEATH\* was as follows:*Carcinoma Mediastini*(duration) *7* yrs. *7* mos. *—* ds.CONTRIBUTORY  
(Secondary)(duration) *—* yrs. *—* mos. *—* ds.18. Where was disease contracted  
if not at place of death? *No*Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *W. H. Howell*, M. D.

3/5/1922

(Address) *119 N Carrollton Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*St. Hubert's Church**3/5 1922*

20. UNDERTAKER

ADDRESS

*Sam'l. L. Loomis**107 E. Biddle*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

S. A. F. E. T. Y. A.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61955  
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

D 61955

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. *4 Main St. Arling*)2-FULL NAME *William F. Camoles*(a) RESIDENCE NO. *4 Main St. Arling*

(Usual place of abode)

Length of residence in city or town where death occurred *1 yr.*

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## MEDICAL CERTIFICATE OF DEATH

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Single*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 10 - 1918*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore Md*10 NAME OF FATHER *William D. Camoles*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore Md*12 MAIDEN NAME OF MOTHER *Blanche Wigginton*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore Md*

14

Informant (Address) *4 Main St. Arling*

15

MAR 5 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

16 DATE OF DEATH (month, day, and year) *3/4/22* 1922-17 I HEREBY CERTIFY, That I attended deceased from *March 1/22*, 19 *22*, to *March 4*, 19 *22*that I last saw him alive on *March 4*, 19 *22*, at *11 a.m.*and that death occurred, on the date stated above, at The CAUSE OF DEATH\* was as follows: *Dysentery*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *No*Date of *March 4*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *W. R. Krauter*3/4, 1922 Address *Arlington*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
BURYAL *Wood Lane*

DATE OF BURIAL

*3/5* 192220 UNDERTAKER *William Cook*ADDRESS *502 E. North*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61956

D 61956

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4315 Harbor Road ST., 7 WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 4315 Harbor Road ST., 7 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White 5 Single, Married, Widowed, Divorced, (write the word) Widowed6 If married, widowed or divorced HUSBAND of (or) WIFE of Ann Rostrey6 DATE OF BIRTH (month, day, and year) Oct 14/18507 AGE Years 71 Months Days LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England10 NAME OF FATHER Charles Oats11 BIRTHPLACE OF FATHER (city or town) (State or country) England12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) England14 Informant Ann Rostrey (Address) 4315 Harbor Rd15 MAR 5 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 3 192217 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to Mar 3, 1922, that I last saw her alive on Mar 7, 1922, and that death occurred, on the date stated above, at 8:30 m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage  
(Heart)  
(Hemiplegia)

(duration) yrs. mos. ds.

CONTRIBUTORY Arteriosclerosis  
(Secondary) and Hypertension  
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of..

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles J. Smith, M. D., 19 (Address) 8706 Harford Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Woodlawn Cemetery

DATE OF BURIAL

3/6 1922

20 UNDERTAKER

ADDRESS

William Cook 602 E North St

TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61957

D 61957

CITY OF BALTIMORE: (No. *St. Agnes Hospital* ST.: *8* WARD)2-FULL NAME *Julia Langley*(a) RESIDENCE NO. *1763 North Gay Street* ST.: *7th* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *married*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*George M. D. Langley*6 DATE OF BIRTH (month, day, and year) *3/30/1899*7 AGE Years Months Days If LESS than 1 day. hrs. or min.  
*27.*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country)10 NAME OF FATHER *Joseph Noark*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Balto Md.*12 MAIDEN NAME OF MOTHER *Mary Fahn*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Balto Md.*14 Informant *W. W. Scott, M.D.*  
(Address) *St. Agnes Hospital*15 *MAR 5 - 1922* *ROBERT E. KRAUTER*  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/4/22* 1917 I HEREBY CERTIFY, That I attended deceased from  
*6 p.m. 3/3/22*, 19, to *7 a.m. 3/4/22*, 19  
that I last saw her alive on *Monday 3/4/22*, 19  
and that death occurred, on the date stated above, at *7 a.m.* m.

The CAUSE OF DEATH\* was as follows:

*Eclampsia of pregnancy*18 *18 hours* (duration) yrs. mos. ds.  
CONTRIBUTORY *Convulsions* *15 hours*  
(Secondary) (duration) yrs. mos. ds.18 Where was disease contracted *At home*  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *None made*(Signed) *W. W. Scott* M. D.. 19 (Address) *St. Agnes Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Balto Am.**3/8/22* 19

20 UNDERTAKER

*Wm. Brook*

ADDRESS

*502 E. North  
ave.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 61958

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61958

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal HospitalST.: 2 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James McCracken(a) RESIDENCE. NO. 408 Park St.

(Usual place of abode)

ST.: 3 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. 10 mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Widowed5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofUnknown6 DATE OF BIRTH (month, day, and year) 9/12/1852

7 AGE

Years

Months

Days

69----If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workBricklayer(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore,Maryland

10 NAME OF FATHER

George McCracken

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mandy Walden

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant

Hospital Records,

(Address)

Municipal Hospital.

15

Filed

MAR 5 - 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Bakham-lem.

UNDERTAKER

Wm. Cook

DATE OF BURIAL

3/6/22

ADDRESS

602 E. North  
ave

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 19 22

17

I HEREBY CERTIFY, That I attended deceased from

February 27, 1922, to March 3, 1922.that I last saw him alive on March 2, 1922.and that death occurred, on the date stated above, at 1:10 A.M.

The CAUSE OF DEATH\* was as follows:

Myocardial insufficiency  
(duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

Clyde McNeill

M. D.

3/3/1922 Address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Bakham-lem.

UNDERTAKER

Wm. Cook

DATE OF BURIAL

3/6/22

ADDRESS

602 E. North  
ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61959

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1106 S. Decker Ave* ST. *4* WARD)

## 2-FULL NAME

(a) RESIDENCE. NO. *1106 S. Decker Ave* ST. *4* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

*13* ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed,

or Divorced (write the word)

*Single*

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Feb 19-22*

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*13*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore*

10 NAME OF FATHER

*John Thamer*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Md*

12 MAIDEN NAME OF MOTHER

*Laura Kent*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Md*

14

Informant (Address)

*John Thamer 1106 S. Decker Ave*

15

Filed

MAR 5 - 1922

19

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Mar 4 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar 1 1922 to Mar 4 1922*that I last saw him alive on *Mar 4 1922*and that death occurred, on the date stated above, at *8 P. M.*

The CAUSE OF DEATH\* was as follows:

*Broncho Pneumonia*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Norace Tiltow* M. D.*3/5, 1922* (Address) *315 S. Highland Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Matthews* *3/6 1922*

20 UNDERTAKER

ADDRESS

*Philip Herzig* *2916 Orleans*



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61960

## CERTIFICATE OF DEATH.

D 61960

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 19 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Wilson(a) RESIDENCE. NO. 207 S. Monroe St. ST. 19 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18537 AGE 68 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland10 NAME OF FATHER Andrew Wilson11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)12 MAIDEN NAME OF MOTHER Susanna Duff13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)14 Informant Hospital Records, (Address) Municipal Hospital.15 MAR 5 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3, 192217 I HEREBY CERTIFY, That I attended deceased from January 19, 1922, to March 3, 1922, that I last saw him alive on March 3, 1922, and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of RectumCONTRIBUTORY Paralytic ileus (duration) 6? yrs. mos. ds. (Secondary) (duration) 2 yrs. mos. ds.

18 Where was disease contracted — if not at place of death?

Did an operation precede death? yes Date of 2-4-22 2-27-22Was there an autopsy? noWhat test confirmed diagnosis? operative findings (Signed) C. H. Brumbaugh, M. D.3/4/1922 Address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

London Park3/6 1922

## 20 UNDERTAKER

Philip Herwig

## ADDRESS

2016Delaware

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

D 61961

## HEALTH DEPARTMENT—CITY OF BALTIMORE

61961

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 23 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy Jamison(a) RESIDENCE. No. 1123 S. sharp st.  
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Divorced5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofNot given6 DATE OF BIRTH (month, day, and year) 18967 AGE Years Months Days  
26 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)North Carolina10 NAME OF FATHER Geo. Caldwell11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Unknown12 MAIDEN NAME OF MOTHER Lula Murray13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)North Carolina14 Informant Hospital Records  
(Address) H. T. H.15 MAR 5 - 1922 ROBERT R. KRAUTER  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2, 192217 I HEREBY CERTIFY, That I attended deceased from  
February 10, 19 22, to March 2, 19 22,  
that I last saw her alive on March 2, 19 22.and that death occurred, on the date stated above, at 10.45 p. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(duration) 2 yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? UnknownDid an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? E. B. in sputum, X-ray

(Signed)

Francis L. Dadoy Hall M. D.

3-3-22

(Address)

Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. AuburnMar 5 1922

20 UNDERTAKER

ADDRESS 142John H. Toading until 5x

D 61962

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61962

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 16 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Bates(a) RESIDENCE. No. 914 Franklin RoadST. 16 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
----------------------	---------------------------------	---

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
<u>60</u>		<u>--</u>	<u>--</u>	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington, D.C.  
(State or country)10 NAME OF FATHER Joseph Bates11 BIRTHPLACE OF FATHER (city or town)  
(State or country) England12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Unknown14 Informant Hospital Records,  
(Address) Municipal Hospital.15 MAR 5 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3, 1922

17 I HEREBY CERTIFY, That I attended deceased from  
June 26, 1921 to March 3, 1922  
that I last saw him alive on March 2, 1922  
and that death occurred, on the date stated above, at 1:00 A.M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Cheekinfection (duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Chemical findings  
(Signed) L. H. Brumback M. D.3/3/1922 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Olver CountyMar 6 1922

20 UNDERTAKER

ADDRESS

St. Mary's hall 3539 Fall Rd

mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61963

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Grand View Ave. near Melvale Ave.* ST., *37* WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

65 yrs. - mos. - ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

MAR 5 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from March 2, 1922, to March 3, 1922, that I last saw her alive on March 2, 1922, and that death occurred, on the date stated above, at 1:45 p. m.

The CAUSE OF DEATH\* was as follows:

Arterio-sclerosis and Chronic myocarditis Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Examination

(Signed) M. D.

3/5, 1922 (Address) 3429 Chestnut St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

ADDRESS

Horace A. Burgee

3631 Falls Rd.

DATE OF BURIAL

March 6, 1922

3631 Falls Rd.

nation should be carefully supplied. Exact statement of OCCASION CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

N.B.—Every item of information should be carefully checked, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

9603  
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61964

CERTIFICATE OF DEATH.

170 D 61964  
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Joseph Hospital* ST. *3* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1417 Bank St*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
*30* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*

4-COLOR OR RACE *White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word) *Married*

6-DATE OF BIRTH

*Unknown* (Month) (Day) (Year) *1*

7-AGE

*42* yrs. mos. ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

*Sailor*  
*at Home*

9-BIRTHPLACE, (State or Country),

*Poland*

10-NAME OF FATHER,

*Unknown*

11-BIRTHPLACE OF FATHER (State or Country),

*Germany*

12-MAIDEN NAME OF MOTHER

*Not known*

13-BIRTHPLACE OF MOTHER (State or Country),

*Not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Stephana Kotz*

(Address) *1417 Bank St*

15-

MAR 5 - 1922

ROBERT R. KRAUTER,

Filed

191

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

*May 3*, 1912  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held as (Inquest, autopsy or inquiry.)

thereof and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Suicide by pistol*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *John J. Minton* M. D.

(Coroner.)

*3-3-1912* (Address) *4 E. 1st St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death.

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL

DATE OF BURIAL

*St. Mary's Hospital* *35*, 1922

20-UNDERTAKER

ADDRESS

*Wm. Gialkowski* *118 Eastern Ave.*

D 61965 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH.

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-2261-5871

ROBERT R. KRAUTER,

Filed....., 191..... Burial Permit Clerk, Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

Mar 3 1922, to Mar 3 1922,

that I saw him alive on Mar 3 1922,

and that death occurred, on the date stated above, at 10:45 m.

The CAUSE OF DEATH\* was as follows:

Cerebral Embolus

and arteriosclerosis

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) Cerebral Aneurysm

(Duration)..... yrs..... mos..... ds.

(Signed) C. H. Smith M. D.

Mar 5, 1922 (Address) 4706 E. Frederick

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Parkwood Green 3/5/22

20-UNDERTAKER ADDRESS

J. E. Walker 722 Lafayette

N.B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bka.

D 61966

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 61966

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 University Hospital ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs. Kate Haymire

(a) RESIDENCE. NO.

Woodlawn, Md. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

8

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Jacob Haymire

6 DATE OF BIRTH (month, day, and year)

7 AGE

Year

Months

Days

If LESS than 1 day, hrs. or min.

64

8

0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Woodlawn Md.

10 NAME OF FATHER Henry Exmire

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER Rose ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant Henry Haymire  
(Address) Woodlawn, Md.

15

MAR 5 - 1922 ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 4 19 22

17

I HEREBY CERTIFY, That I attended deceased from Feb. 25, 19 22, to Mar 4, 19 22, that I last saw her alive on Mar. 3, 19 22, and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH\* was as follows:

fracture of skull in rt. temporal region due to kick of horse

(duration)

yrs.

mos.

8

CONTRIBUTORY (Secondary)

Septic Meningitis

(duration)

yrs.

mos.

ds.

2

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of Feb. 25/22

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed)

J. Willis Guyton, M. D.

Mch. 4 1922

University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Olive (Roslyn, Md.)

3/7 19 22

20 UNDERTAKER

Joe Cook

ADDRESS

103 W. 3rd St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

001 61967

D 61967

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 819-W-North Av.

ST.: 14 WARD)

## 2-FULL NAME

Fleta Harrison Tate

## (a) RESIDENCE. No.

819-W-North-Av.

ST.. 14 WARD.

(Ramseur, N.C.)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

0 yrs. few mos. ?

ds. How long in U. S., if of foreign birth? 19 yrs. 1 mos. 3 ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

(Single)

## 6 DATE OF BIRTH (month, day, and year) Feb-2-1903

## 7 AGE

19

Years

Months

1

Days

3

If LESS than  
1 day. hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Student at the

(b) General nature of industry, business, or establishment in which employed (or employer)

Peabody Institute

(c) Name of employer

(none)

9 BIRTHPLACE (city or town)  
(State or country)Ramseur N.C.  
N.C.

## 10 NAME OF FATHER Charles S. Tate

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Burgone  
N.C.

12 MAIDEN NAME OF MOTHER Mary Ida Campbell

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Clarkton  
N.C.14 Informant Charles S. Tate (father)  
(Address) Ramseur, N.C.

15

MAR 5 - 1922

ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar-4-1922

17

I HEREBY CERTIFY, That I attended deceased from

9 a.m., Mar 2, 1922, to 11.20 P.M., Mar 4, 1922.

that I last saw her alive on Mar 4, 1922.

and that death occurred, on the date stated above, at 11.20 P.M.

The CAUSE OF DEATH\* was as follows:

Pneumonia lobar

(duration) yrs. mos. 3 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

James C. Clarke, M.D.  
Zorbe Opt. Chas. Real etc

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Ramseur, N.C.

Mar-5-22 19

## 20 UNDERTAKER

STEWART & MOWEN COMPANY  
(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.

Information should be carefully supplied. Every statement of occurrence should be properly classified. Exact statement of occurrence should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

**HEALTH DEPARTMENT—CITY OF BALTIMORE**  
**D 61968** **61968**  
**CERTIFICATE OF DEATH.**

**1-PLACE OF DEATH**

CITY OF BALTIMORE: (No. 4109-Ridgewood-Av.

ST. 15 WARD)

REGISTERED NO. \_\_\_\_\_  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

**2-FULL NAME** Mary Rosalie Hammond

(a) **RESIDENCE. NO.** 4109-Ridgewood Av.

ST. 15 WARD. (Resident)

(Usual place of abode) Length of residence in city or town where death occurred 73 yrs. 7 mos. 4 ds. How long in U. S., if of foreign birth? 73 yrs. 7 mos. 4 ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3 SEX** Female **4 COLOR OR RACE** White **5 Single, Married, Widowed, or Divorced (write the word)** Married

**5a If married, widowed, or divorced**  
 HUSBAND of (or) WIFE of Henry Dorsey Hammond.

**6 DATE OF BIRTH (month, day, and year)** July-30-1848

**7 AGE** Years 73 Months 7 Days 4 If LESS than 1 day, hrs. or min.

**8 OCCUPATION OF DECEASED**  
 (a) Trade, profession or particular kind of work None  
 (b) General nature of industry, business, or establishment in which employed (or employer) None  
 (c) Name of employer None

**9 BIRTHPLACE (city or town)** Baltimore  
 (State or country) Maryland

**10 NAME OF FATHER** Richard Walsh  
**11 BIRTHPLACE OF FATHER (city or town)** Baltimore  
 (State or country) Maryland  
**12 MAIDEN NAME OF MOTHER** Eliza Lestner  
**13 BIRTHPLACE OF MOTHER (city or town)** Baltimore  
 (State or country) Maryland

**14 Informant** Henry D. Hammond (husband)  
 (Address) 4109-Ridgewood-Av., City.

**15** 2661-5811 **ROBERT H. KRAUTER,**  
 Registrar  
 Burial Permit Clerk.

**MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH (month, day, and year)** March 4 19 22

**17 I HEREBY CERTIFY** that I attended deceased from Jan 30, 19 22, to March 4, 19 22, that I last saw her alive on March 3, 19 22, and that death occurred, on the date stated above, at 5 2 m.

The CAUSE OF DEATH\* was as follows:  
Hemiplegia (Right)  
over

**CONTRIBUTORY** (Secondary) Arterio Sclerosis  
 (duration) 2 yrs. 5 mos. 7 ds.

**18 Where was disease contracted** if not at place of death?  
 Did an operation precede death? No Date March 4  
 Was there an autopsy? No

What test confirmed diagnosis?  
 (Signed) Wm. G. Queen M. D.  
 (Address) 3501 Garrison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

**19 PLACE OF BURIAL, CREMATION OR REMOVAL** DRUID RIDGE CEMETERY **DATE OF BURIAL** MAR-6-22

**20 UNDERTAKER** STEWART & MOWEN COMPANY **ADDRESS** 108 W. NORTH AVE.  
 (WILLIAM F. WOODEN, Successor)

Information should be carefully supplied. Cause of death should be stated in plain terms, so that it may be properly classified. See instructions on back of certificate.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Apoplectic. Terminal  
hemorrhage.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

ST.: WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. 10 mos. 0 ds. How long in U. S., if of foreign birth? 38 yrs. 10 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 4, 1883

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

38

10

0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerical

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, MD

10 NAME OF FATHER

William Dankmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore, MD

12 MAIDEN NAME OF MOTHER

Anna Stinkler

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, MD

14

Informant (Address)

15

MAR 5 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4<sup>th</sup> 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 14<sup>th</sup>, 1922, to March 4<sup>th</sup>, 1922,that I last saw him alive on March 4<sup>th</sup>, 1922,and that death occurred, on the date stated above, at 10<sup>45</sup> P. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis -

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

710 W. Fayette St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. Couder, M. D.

, 19 (Address) Johns Hopkins Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lorden Park Cemetery

Mar 7 1922

20 UNDERTAKER

STEWART &amp; MOWEN COMPANY

(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61970

D 61970

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1004 E Madison St. ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME James Berry

(a) RESIDENCE. No. 1004 E Madison St.

(Usual place of abode)

WARD. Washington Dc.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 8 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

col.

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Ella Berry

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

48

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Md

10 NAME OF FATHER James Berry

11 BIRTHPLACE OF FATHER (city or town)

Md

(State or country)

12 MAIDEN NAME OF MOTHER Henrietta Berry

13 BIRTHPLACE OF MOTHER (city or town)

Md

(State or country)

14

Informant (Address)

Margaret Harkins 1004 E Madison St.

MAR 3 - 1922

ROBERT R. KRANTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 30, 1921 to March 1922.

that I last saw him alive on March 3, 1922.

and that death occurred, on the date stated above, at 6:20 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis and Prostatic Hypertrophy of heart (duration) yrs. 6 mos. ds.

CONTRIBUTORY

(Secondary)

Age and Arteriosclerosis (duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?

no

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

Physical Exam

(Signed)

G. D. Hall

M. D.

19 (Address)

426 E 28 St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Washington D. C.

March 1922

20 UNDERTAKER

ADDRESS

Mrs J. G. Locks

1302 Jefferson

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61974

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 East North Ave. ST. 12 WARD)

2-FULL NAME Mary P. Murphy

(a) RESIDENCE. NO. 225 East North Ave. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE 56 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

10 NAME OF FATHER John Murphy

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Anna Dugan

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Miss Anna Murphy (Address) 225 East North Ave.

15 MAR 5 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 3 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1921, to Mar 3 1922, that I last saw her alive on Mar 3rd, 1922, and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH\* was as follows:

Carcinoma Rt. Breast

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

Haemorrhage (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 30 - 1921

Was there an autopsy? No

What test confirmed diagnosis? Microscopical section (Signed) Harry R. Slack, Jr., M. D.

19 (Address) 1100 N. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery DATE OF BURIAL Mar. 7, 1922

20 UNDERTAKER

ADDRESS

Henry W. Mears &amp; Son, 805 N. Calvert

CAUTION: This is a duplicate of the original. It is not to be used for legal purposes. The original is the only one to be used for legal purposes. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61972

## CERTIFICATE OF DEATH.

1240 61972

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. *2031 Dwyer St.*)ST. *14* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Adrian Johnson*(a) RESIDENCE. No. *2031 Dwyer St.*

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *40* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*Colored*5 Single, Married, Widowed,  
or Divorced (write the word)*Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *1864*

7 AGE

*55* Years*9* Months

Days

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Huckster 045*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)*None*

(c) Name of employer

*None*9 BIRTHPLACE (city or town)  
(State or country)*Washington D.C.*

10 NAME OF FATHER

*Adrian Johnson*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Washington*

12 MAIDEN NAME OF MOTHER

*Polly Johnson*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Washington*

14

Informant  
(Address)*Mr. Annie Johnson  
2031 Dwyer St.*

15

MAR 5 - 1922

ROBERT R. KRAUTER,  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/3* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from  
*3/1* 19 *22*, to *3/3* 19 *22*  
that I last saw him alive on *3/3* 19 *22*  
and that death occurred, on the date stated above, at *11:30* A.M.

The CAUSE OF DEATH\* was as follows:

*Chr. nephritis &  
Uremia*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Frank R. Little*, M. D., 19 (Address) *213 D. St.*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Local Cemetery**March 6 1922*

20 UNDERTAKER

ADDRESS

*John H. Owens**538 Dwyer St.*

mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61973

## CERTIFICATE OF DEATH.

D 61973

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

3101 Presbury

ST.

WARD) 16

## 2-FULL NAME

Thomas J. Brown

(a) RESIDENCE No.

3101 Presbury

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

39 yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary R Brown

6 DATE OF BIRTH (month, day, and year)

Oct. 5, 1837

7 AGE

84

Years

Months

4

Days

26

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Landscape Gardener

(b) General nature of industry, business, or establishment in which employed (or employer)

086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Brooks Co Pa

10 NAME OF FATHER

Geo. Brown

11 BIRTHPLACE OF FATHER (city or town)

Hart Pa.

(State or country)

12 MAIDEN NAME OF MOTHER

Marie Closon

13 BIRTHPLACE OF MOTHER (city or town)

Pa

(State or country)

14

Informant (Address)

Mary R Brown 3101 Presbury St.

15

MAR 5 - 1922

ROBERT H. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

Dec 6, 1921, to Mar 3, 1922.

that I last saw him alive on Mar 2, 1922,

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma tons, nodes across back, main part on neck.

CONTRIBUTORY (Secondary)

Mole on back removed by 3/3, 1922. (duration) 8 yrs. 8 mos. 24 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

yes Date of Aug 1, 1921

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. E. Knapp M. D.

3/3, 1922 (Address) 1002 W. Lenoir

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park Ave

3/6/22

20 UNDERTAKER

Wm. The Knickerbocker North Pa

N. B.—WRITE PLAINLY, WITH CARE. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

61974  
D 61974

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 44 E West

ST. 23 WARD)

## 2-FULL NAME

Mary Karangelen

## (a) RESIDENCE NO.

44 E West

ST.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

1 yrs.

mos.

25 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Feb 10 1922

## 7 AGE

Years

Months

Days

1

X

25

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town, State or country)

Baltimore

## 10 NAME OF FATHER

Mr. Karangelen

## 11 BIRTHPLACE OF FATHER (city or town, State or country)

Greece

## 12 MAIDEN NAME OF MOTHER

Mary Soterokos

## 13 BIRTHPLACE OF MOTHER (city or town, State or country)

Greece

## 14

Informant  
(Address)William Karangelen  
44 E West St.

## 15

MAR 6 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Mar 5 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

2/27/22, 19 to 3/5/22, 19

that I last saw her alive on 3/5/22

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

CONTRIBUTORY (Secondary) microcephalus  
(duration) yrs. mos. 3 ds.  
(duration) lifetime mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Thorax of Pneumonia

(Signed) Walter C. Bacon, M. D.

3/5/22 (Address) 100 E 20th St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Woodlawn Cem

## DATE OF BURIAL

Feb 6 1922

## 20 UNDERTAKER

Robert Brookhouse

## ADDRESS

Baltimore

28

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61976

## CERTIFICATE OF DEATH.

REGISTERED NO. C

161-102  
D 61976

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4002 Cottage ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 4002 Cottage ave St.: yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE.

White

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Single

## 6-DATE OF BIRTH.

3 4, 1922  
(Month) (Day) (Year)

## 7-AGE.

yrs. mos. ds.

## If LESS than 1 day.

5 hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE, (State or Country).

Md.

## 10-NAME OF FATHER.

Wellington Weis

## 11-BIRTHPLACE OF FATHER (State or Country).

Ind

## 12-MAIDEN NAME OF MOTHER

Helen King

## 13-BIRTHPLACE OF MOTHER (State or Country).

Ind

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wellington Weis

(Address) 4002 Cottage ave

## 15-

MAR 6 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

3 4, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Mar 4 1922, to Mar 4 1922,

that I saw him alive on Mar 4 19122,

and that death occurred, on the date stated above, at 11 P m.

## The CAUSE OF DEATH\* was as follows:

Forceful delivery - Mal Presentation

Difficult delivery

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. H. Beeton M. D.

3 5, 1922 (Address) Mt. Washington

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

## DATE OF BURIAL.

David Ridge March 6, 1922

## 20-UNDERTAKER

## ADDRESS

Robert R. Krauter Edmondson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# D 61977 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61977

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *639 W. Lafayette Ave.* ST. *17* WARD)2-FULL NAME *George A. Howard*(a) RESIDENCE. NO. *639 W. Lafayette Ave.* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *6* yrs. *—* mos. *—* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>Colo'd</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Married</i>
----------------------	----------------------------------	--

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *—*6 DATE OF BIRTH (month, day, and year) *Unknown 1832*

7 AGE <i>90</i>	Years	Months	Days	If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Plasterer 051*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Va.*  
(State or country)10 NAME OF FATHER *Paul Howard*11 BIRTHPLACE OF FATHER (city or town) *Va.*  
(State or country)12 MAIDEN NAME OF MOTHER *Don't know*13 BIRTHPLACE OF MOTHER (city or town) *Unknown*  
(State or country)14 Informant *Marie Jones*  
(Address) *639 W. Lafayette Ave.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 3d 1922*17 I HEREBY CERTIFY, That I attended deceased from *Feb. 25, 1922* to *March 3, 1922*  
that I last saw him alive on *March 2, 1922*and that death occurred, on the date stated above, at *9:50 P. M.*

The CAUSE OF DEATH\* was as follows:

*Valvular Heart disease from Hysteria about 1 year*  
(duration) yrs. mos. ds.CONTRIBUTORY *Don't know*  
(Secondary) (duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? *Don't know*Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*What test confirmed diagnosis? (Signed) *H. H. Gorman, M. D.*3322 (Address) *117 W. Saratoga St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Ind. Auburn City Mar 6 1922*

20 UNDERTAKER ADDRESS

*George H. Hollans 1631 Krumpholtz Ave*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MAR 6 - 1922

MAR 6 - 1922

ROBERT H. KRAUTER,  
Registrar  
Burial Permit Clerk



## HEALTH DEPARTMENT—CITY OF BALTIMORE

61978

D 61978

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE, NO.

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15

MAR 6 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from 10/21/22, to 3/4/22, that I last saw him live on Mar 4, 1922, and that death occurred, on the date stated above, at 5:25 P.M.

The CAUSE OF DEATH\* was as follows:

General Exhaustion (duration) yrs. 3 mos. 3 ds.

CONTRIBUTORY

Secondary right breast carcinoma of the (duration) yrs. 8 mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? yes

What was the confirmed diagnosis?

(Signed)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOV.

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 61979

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61979

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 1543 Orleans ST.; 6 WARD)

## 2-FULL NAME

Hannah Fleishacker

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE. NO.

1543 Orleans ST.,

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female White Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 75 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

10 NAME OF FATHER Moses Fleishacker

11 BIRTHPLACE OF FATHER (city or town) Germany

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) Germany

14 Informant Mrs. Isaac (Address) 1543 Orleans St.

15 MAR 6 - 1922 ROBERT R. KRAUTER Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4 1922

17 I HEREBY CERTIFY, That I attended deceased from

4th 15, 1922, to Mar 4, 1922,

that I last saw her alive on Mar 3rd, 1922,

and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH\* was as follows:

Senility

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. R. Tinsley, M. D.

3/5, 1922 Address) 2013 Bank

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Hebrew Cem 3/6 1922

20 UNDERTAKER ADDRESS

J. Ahrens Co 16 N. Kent St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61980

## CERTIFICATE OF DEATH.

185 D 61980

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3716 Springdale Ave ST. 15 WARD)2-FULL NAME Alice McRae Meakin

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 3716 Springdale Ave St.; 21 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE,

White

## 5-SINGLE,

MARRIEDWIDOWEDOR DIVORCED

(Write the word.)

## 6-DATE OF BIRTH,

Feb11848

(Month)

(Day)

(Year)

## 7-AGE,

7413

ds.

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, business, or establishment in which

employed (or employer).

## 9-BIRTHPLACE,

(State or Country),

N.C.

## 10-NAME OF FATHER,

S. H. McRae

## 11-BIRTHPLACE OF FATHER

(State or Country),

N.C.

## 12-MAIDEN NAME OF MOTHER

Sarah Wood

## 13-BIRTHPLACE OF MOTHER

(State or Country),

N.C.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

W. L. Meakin

(Address)

3716 Springdale Ave

MAR 6 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

341922

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Feb. 23, 1922, to March 4, 1922that I saw her alive on March 4, 1922and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Fracture of leftforearm (Duration) yrs. mos. ds.(Signed) W. L. Meakin M. D.3/4, 1922 (Address) 3121 Garrison Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (i) MEANS OF INJURY; and (s) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL

St. Olm's Cem. Mount Airy, 1922

## 20-UNDERTAKER

ADDRESS

Chas E Branch 807 Madison Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61981

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1723 Homestead ST., 9 WARD)2. FULL NAME Mary M. Meyers(a) RESIDENCE NO. 1723 Homestead ST., 9 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. 0 mos. 0 ds.

yrs.

ds.

How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Meyers6 DATE OF BIRTH (month, day, and year) Apr 4 / 1843

7 AGE

Years 78

Months

Days

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England10 NAME OF FATHER John W. Meyers11 BIRTHPLACE OF FATHER (city or town) (State or country) England12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14

Informant Harman Meyers(Address) 1723 Homestead St.

MAR 6 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4 192217 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1922, to Mar 4, 1922.that I last saw her alive on Mar 4, 1922.and that death occurred, on the date stated above, at 7-45 P. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos. 12

ds.

(duration)

yrs.

mos. 2

ds.

18 Where was disease contracted if not at place of death? NoDid an operation precede death? No

Date of

Was there an autopsy? NoWhat test confirmed diagnosis? Clinical(Signed) R. R. Campbell, M. D.Address 1644 Hancock St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Parkwood Cemt.

DATE OF BURIAL

3-6 1922

20 UNDERTAKER

ADDRESS

William Cook. 502 E. North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE CAREFULLY SUPPLIED. CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.



D 61982

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61982

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: No.

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan 1, 1922, to Mar 4, 1922.

that I last saw him alive on Mar 2, 1922.

and that death occurred, on the date stated above, at 3:00 p.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

Chronic Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Spinal Puncture

(Signed) W. D. Wells, M. D.

, 19 (Address) Ashley Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt. Olivet

20 UNDERTAKER

H. M. Corkin

DATE OF BURIAL

Mar. 5, 1922

ADDRESS

H. M. Corkin

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

M.

W

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Florence Gorman

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

47

8

22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Soldier

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Don't Know

12 MAIDEN NAME OF MOTHER

Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Don't Know

14 Informant

Florence E. Gorman

(Address)

1807 W Lexington

15

MAR 6 - 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk,

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 61983

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61983

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 937 N. Patterson Pk Ave ST. 7 WARD)

## 2. FULL NAME

(s) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Nov 15, 1922 to March 3, 1923

that I last saw her alive on March 3, 1922

and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH\* was as follows:

Acute Pyophobic Typhemia  
acute Rheumatic Fever  
general adenitis, uterine  
regeneration (duration) yrs. 4 mos. ds.

CONTRIBUTORY antedromic chorea (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? findings

(Signed)

F. F. Rhyder, M. D.  
3-4-1922 (Address) 600 N. Patterson Pk Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

MAR 6 - 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61984

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

St. Vincent's Inf. Asy.

CITY OF BALTIMORE: (No. 1401- Division

ST.,

WARD)

2-FULL NAME

Joseph Schene

(a) RESIDENCE NO.

St. Vincent's Inf. Asy.

(Usual place of abode)

ST.,

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

5 mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

Sept. 28, 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

None

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Charles Gacher

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Alice Schene

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

St. Vincent Inf. Asy.

15

761-9844

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8, 1922

17 I HEREBY CERTIFY, That I attended deceased from

3/2/1922, to 3/3/1922.

that I last saw him alive on March 3, 1922.

and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH\* was as follows:

Malnutrition

CONTRIBUTORY (Secondary) Myocardial Insufficiency.

(duration)

yrs.

5 mos.

ds.

(duration)

yrs.

3 mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Eadsborough, M. D.

19 (Address) 2735 N. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL

20 UNDERTAKER

Mt. Olivet Home March 6, 1922

ADDRESS

Martin Fahey Son 1827 W. Voth

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A STATISTICAL RECORD. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61985

## CERTIFICATE OF DEATH

REGISTERED NO.

D 61985

1-PLACE OF DEATH

University Hospital

CITY OF BALTIMORE: (No.

Lombard + Green ST. 4th WARD)

2-FULL NAME

James L. Charles

(a) RESIDENCE. No.

Overlea Mrs. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. - mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed,  
or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of

Eva Charles

6 DATE OF BIRTH (month, day, and year)

1865

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

57

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Sea Captain

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Maryland

10 NAME OF FATHER

James Charles

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary Ellen ??

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

??

14

Informant  
(Address)Mrs Eva Charles  
Overlea Mrs.

15

Filed

MAR 6 - 1922

ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

march 2, 1922, to march 3, 1922

that I last saw him alive on march 3, 1922

and that death occurred, on the date stated above, at 8:45 p.m.

The CAUSE OF DEATH\* was as follows:

Cardiac failure

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.  
Lobar pneumonia right side18 Where was disease contracted  
if not at place of death?

no

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical findings

(Signed)

R. J. Phyller

19

(Address)

University Hospital  
Lombard + Green Sts\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cemetery March 7 1922

20 UNDERTAKER

Jos. Frederickson &amp; Son 217 S. B.



D 61986 HEALTH DEPARTMENT—CITY OF BALTIMORE D 61986

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 921 Bennett Pl. 18 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. 921 Bennett Pl. WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 2, 1893

7 AGE Years 29 Months 1 Days 2 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER John H. Gleason

11 BIRTHPLACE OF FATHER (city or town) Frederick (State or country)

12 MAIDEN NAME OF MOTHER Grace S. Cranklett

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

## 14

Informant (Address)

## 15

Filed

MAR 6 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 21, 1922, to March 4, 1922,

that I last saw him alive on March 4th, 1922,

and that death occurred, on the date stated above, at 10:20 P. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia Tuberculosis

CONTRIBUTORY (Secondary)

(duration) unknown

Tuberculosis Secondary

(duration) yrs. 2 mos. ds.

18 Where was disease contracted

if not at place of death? Unknown

Did an operation precede death? no

Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum Examination

(Signed) W. H. Riggs, M. D.

, 19 (Address) 2429 N. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A STATISTICAL RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 61987  
100-001

1-PLACE OF DEATH  
CITY OF BALTIMORE (No. 612 Vincent St. 16 WARD)  
2-FULL NAME Evelyn Washington  
(Residence in Baltimore: No. 612 Vincent St. St.; yrs., 5 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female  
4-COLOR OR RACE, colored  
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)  
6-DATE OF BIRTH, Sep 17, 1924  
(Month) (Day) (Year)  
7-AGE, 5 yrs., 17 mos., 17 ds.  
If LESS than 1 day, ....hrs. or ....min.  
8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, (Infant)  
(b) General nature of industry, business, or establishment in which employed (or employer), (Home)

9-BIRTHPLACE, (State or Country), Balto. Md.

10-NAME OF FATHER, James Washington  
11-BIRTHPLACE OF FATHER, D. C.  
12-MAIDEN NAME OF MOTHER, Ethel Walker  
13-BIRTHPLACE OF MOTHER, D. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) James Washington  
(Address) 612 Vincent St.

15-ROBERT R. KRAUTER,  
MAR 6 - 1925 Burial Permit Clerk,  
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 4, 1925  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.  
The CAUSE OF DEATH\* was as follows:

Branches - pneumonia  
(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) no history  
(Duration) .... yrs. .... mos. .... ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)  
March 5, 1925 (Address) 2802 Cambridge

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Int. Burial Co. DATE OF BURIAL, March 6, 1925

20-UNDERTAKER, Mrs. Robert A. Elling ADDRESS 1723

D 61988

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61988

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: NO.

ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Widow of James Hamilton

6 DATE OF BIRTH (month, day, and year)

1880

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

42

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

Private

(c) Name of employer

Mrs. James Amherst Co

9 BIRTHPLACE (city or town) (State or country)

James Hamilton

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAR 6 - 1922 ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 24 1922, to March 2 1922

that I last saw him alive on March 2 1922

and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH\* was as follows:

Acute Pericarditis

CONTRIBUTORY (Secondary) Ex. Heart

(duration) yrs. mos. ds.

18 Where was disease contracted 917 Spruce St

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical

(Signed) J. B. H. M. D.

19 (Address) 1413 Hill Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Auburn Cem Mar 7 1922

20 UNDERTAKER ADDRESS

Samuel Hensley 1413 Hill Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61989

## CERTIFICATE OF DEATH.

90 D 61989

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 Woodley ST., 16 WARD)

## 2. FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 11 mos. 15 ds.

ST.,

WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17, 19227 AGE Years 2 Months 11 Days 15 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hartford

## 14

Informant (Address)

Richard J. Getz  
1118 Woodley St.

MAR 6 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 19 22

17

I HEREBY CERTIFY, That I attended deceased from January 24, 19 22, to March 4, 19 22, that I last saw her alive on March 3, 19 22, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH\* was as follows:

Acute MyocarditisCONTRIBUTORY (Secondary) Valvular Heart Disease (duration) yrs. 2 mos. 2 ds.(duration) yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

3 (Signed) M. A. Smith, M. D.  
15, 19 22 (Address) 108 N. Fulton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral Cemetery

20 UNDERTAKER

James Dequan & Son

DATE OF BURIAL

March 6 19 22

ADDRESS

1000 S. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61990

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1153 Granby St* ST. *3* WARD)2-FULL NAME *Gertie Gerher*(a) RESIDENCE NO. *1153 Granby St*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

ST. *3* WARD

WARD

(If non-resident, give city or town and State)

How long in U. S., if of foreign birth

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F.*4 COLOR OR RACE *m*5 Single, Married, Widowed, or Divorced, (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *6 child*6 DATE OF BIRTH (month, day, and year) *Unknown 1911*

7 AGE

Years *11*

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *School*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *Joe Gerher*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Russia*12 MAIDEN NAME OF MOTHER *Jennie Simulton*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Russia*

14

Informant (Address) *J. Lewis*

15

MAR 6 - 1922

ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-5 1922*17 I HEREBY CERTIFY, That I attended deceased from *March 4, 1922* to *March 5, 1922* that I last saw him alive on *March 4, 1922* and that death occurred, on the date stated above, at *4 P. M.*

The CAUSE OF DEATH\* was as follows:

*Acute Pneumonia*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *3*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. W. H. M. D.*1922 (Address) *224 Bldg*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*William Herrington**Jack Lewis*

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state AGE, should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 61991

HEALTH DEPARTMENT—CITY OF BALTIMORE

160 D 61991

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 536 W Franklin ST.; 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosario Amoroso(Residence in Baltimore: No. 536 W Franklin St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M 4-COLOR OR RACE, W 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, S  
(Write the word.)6-DATE OF BIRTH, Sept. 9<sup>th</sup>, 1921  
(Month) (Day) (Year)7-AGE, 5 yrs., 24 mos., 24 ds.  
If LESS than 1 day, ...hrs. or...min.8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, None  
(b) General nature of industry, business, or establishment in which employed (or employer), ooo9-BIRTHPLACE, (State or Country), Italy10-NAME OF FATHER, Dominico Amoroso11-BIRTHPLACE OF FATHER (State or Country), Italy12-MAIDEN NAME OF MOTHER, Rosa Merante13-BIRTHPLACE OF MOTHER (State or Country), Italy City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dominico Amoroso(Address) 536 W Franklin St.

15- MAR 6 - 1922

Filed..... 191.....  
J. E. Kehn Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3-4, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from 2-27-1922, to 3-4-1922  
that I saw him alive on 3-4-1922  
and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Faulty Metabolism(Duration)..... yrs. 5 mos. 24 ds.CONTRIBUTORY... Starvation...  
(Secondary)(Duration)..... yrs. 5 mos. 24 ds.(Signed) S. J. D. Amoroso M. D.2-4-1922, 1922 (Address) 1604 Franklin St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral CemeteryDATE OF BURIAL, March 6, 192220-UNDERTAKER, W. M. RoutsonADDRESS, 2238 W. M. Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 61992 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 61992

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. *10* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mary Griffin*(a) RESIDENCE. NO. *1041 Harford Ave.* ST. *10* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Levi J. Griffin*6 DATE OF BIRTH (month, day, and year) *1882*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*70*

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Bulte.*

9 BIRTHPLACE (city or town) (State or country)

*Baltimore*

10 NAME OF FATHER

*Not known*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Not known*

12 MAIDEN NAME OF MOTHER

*Not known*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Not known*

14

Informant (Address)

*Mrs. John John 1041 Harford Ave.*

15

MAR 6 - 1922

ROBERT K. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 4 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan. 30, 1922, to March 4, 1922, that I last saw her alive on March 4, 1922.*and that death occurred, on the date stated above, at *11:45 p.m.*

The CAUSE OF DEATH\* was as follows:

*Myocardial Insufficiency*CONTRIBUTORY (Secondary) *Chronic Interstitial nephritis* (duration) *1* yrs. *0* mos. *0* ds.18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *P.S. & S. & Laboratory* (Signed) *F. C. Marino* M. D.19 (Address) *St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Cross**March 7 1922*

20 UNDERTAKER

*E. A. Wiedefeld*

ADDRESS

*301 E 22*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

61993

## CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Mary's Hospital* ST.)

WARD)

(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Alexander Porter*

(Residence in Baltimore: No.

*573 S Polk*

St. yrs.,

mos.

da.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*Male*

4-COLOR OR RACE,

*White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

*October*

*14*

*1873*

(Month)

(Day)

(Year)

7-AGE,

*48*

yrs.

*1* mos.

*20* da.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Conductor*  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

*Ind*

10-NAME OF FATHER,

*Rzal Porter*

11-BIRTHPLACE OF FATHER (State or Country),

*Ind*

12-MAIDEN NAME OF MOTHER

*Mary*

13-BIRTHPLACE OF MOTHER (State or Country),

*Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Porter*

(Address)

15-

Filed

191

*ROBERT R. KRAUTER,*

*Burial Permit Clerk*

MAR 6 - 1922

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Nov*

*4*

*1918*

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

*topsy or inquiry* and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

*Fract. 1st lumbr. vert., with injury to cord*  
*2nd lumbr. vert. with injury to cord*  
(Duration) *12 hrs.* yrs. *6* mos. *6* da.

CONTRIBUTORY (Secondary)

*Pal. Edema*

(Duration)

yrs.

mos.

da.

(Signed) *W. S. Kelly*

(Coroner)

M. D.

*1046*, 101 (Address) *1046*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place *6 days* In the of death *6 days* yrs. *6* mos. *6* da. State *6* yrs. *6* mos. *6* da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

*Cal. Lawn Cemetery*

DATE OF BURIAL,

*Mar. 7*, 19 *22*

20-UNDERTAKER

*Henry Street*

ADDRESS

*1301 E. Eager*



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rls.

D 61994

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

174 D 61994

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1005 Higginth ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Philomena Bohli*

(a) RESIDENCE NO. 1005 Higginth  
(Usual place of abode)

ST., 10 WARD

Length of residence in city or town where death occurred 64 yrs. 3 mos. 15 ds.

(If non-resident, give city or town and State)  
How long in U. S., if of foreign birth? 10 yrs. 6 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*

5a If married, widowed, or divorced  
HUSBAND or (or) WIFE of *St. Ignace Bohli*

6 DATE OF BIRTH (month, day, and year) *Nov. 20 1857*

7 AGE Years Months Days If LESS than 1 day, hrs. or min:  
*64 3 15*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*  
(b) General nature of industry, business, or establishment in which employed (or employer) *ood*  
(c) Name of employer

9 BIRTHPLACE (city or town) *Balls.*  
(State or country)

10 NAME OF FATHER *Anthony Kircher*

11 BIRTHPLACE OF FATHER (city or town) *Germany*  
(State or country)

12 MAIDEN NAME OF MOTHER *Not known*

13 BIRTHPLACE OF MOTHER (city or town) *Not known*  
(State or country)

14 Informant *Miss Mary Bohli*  
(Address) *1005 Higginth St.*

15 Filed *MAR 6 - 1922*

ROBERT R. KRAUTER  
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 5 1922*

17 I HEREBY CERTIFY, That I attended deceased from *March 2*, 1922, to *March 5*, 1922, that I last saw her alive on *March 4*, 1922, and that death occurred, on the date stated above, at *10 A.* m. The CAUSE OF DEATH\* was as follows:

*Fatty degeneration of heart*  
(duration) *2* yrs. *3* mos. *15* ds.

CONTRIBUTORY (Secondary) *27*  
(duration) yrs. *6* mos. *15* ds.

18 Where was disease contracted  
If not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *John C. ...* M. D.  
, 19 (Address) *1927 S. ...*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Holy Redeemer Cemetery*

*March 8 1922*

20 UNDERTAKER

*Henry Brock Sey*

ADDRESS

*1301 E. ...*

D 61995

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST.: *17* WARD)

## 2-FULL NAME

(a) RESIDENCE. NO. *1716 St. Paul* ST.: *WARD.*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Widower*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Widower*

6 DATE OF BIRTH (month, day, and year)

*June 26 1850*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*71**8**7*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Baggage Master*

(c) Name of employer

*Prim R R*

9 BIRTHPLACE (city or town) (State or country)

*Delaware Md*

10 NAME OF FATHER

*Edmund Hackett*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Md.*

12 MAIDEN NAME OF MOTHER

*Mary Riley*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Md*

14

Informant (Address)

*Mrs H. F. Saunders 1627 N. Caroline St*

15

MAR 6 - 1922

ROBERT R. KRAUTER Registrar

Bureau of Health

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 3 1922*17 I HEREBY CERTIFY, That I attended deceased from *March 2 1922* to *March 3 1922* that I last saw him alive on *March 3 1922* and that death occurred, on the date stated above, at *7:40 p.m.*

The CAUSE OF DEATH\* was as follows:

*Myocardial insufficiency*CONTRIBUTORY (Secondary) (duration) *4* yrs. mos. ds. *Lobar pneumonia*18 Where was disease contracted if not at place of death? *at home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *P. S. & S.*(Signed) *Frank C. Marino* M. D.19 (Address) *St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Lowden Park Cemetery 3/5/1922*

20 UNDERTAKER ADDRESS

*C. J. Manning & Son, 1938 E. Lafayette*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

*Prues*  
HEALTH DEPARTMENT—CITY OF BALTIMORE  
CERTIFICATE OF DEATH.

61996

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1008 S Bouldin* ST. *26* WARD)

2-FULL NAME

*Carol Prues*

(a) RESIDENCE. NO. *1008 S Bouldin* ST. *1* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. — mos. — ds. How long in U. S., if of foreign birth? *Life* yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Child*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct 22-1921*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*4*

*10*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

*100*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md*

10 NAME OF FATHER

*John Prues*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Penn*

12 MAIDEN NAME OF MOTHER

*Mary Smith*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Penn*

14

Informant (Address)

*John Prues  
1008 S Bouldin*

15

*MAR 6-1922*

*ROBERT R. KRAUTER*

*Burial Permit Clerk*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 4* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar 1*, 19*22*, to *Mar 4*, 19*22*,

that I last saw him alive on *Mar 3*, 19*22*,

and that death occurred, on the date stated above, at *1:30* pm.

The CAUSE OF DEATH\* was as follows:

*Broncho Pneumonia*

(duration) yrs. mos. *10* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Observation*

(Signed) *Harace B. Titlow*, M. D.

*3/5*, 1922 (Address) *315 S. Highland Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St Stanislaus Church*

*Mar 6* 1922

20 UNDERTAKER

ADDRESS

*Stephen J. Piskowski*

*1008 S Bouldin*

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior  
as far as phy. could  
ascertain*



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

154159 61997

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Edward Lachner

(a) RESIDENCE. No.

111 N. Montford Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov 17 - 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3

15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Child 000

9 BIRTHPLACE (city or town) (State or country)

Baltimore MD

10 NAME OF FATHER

Joseph Lachner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Austria

12 MAIDEN NAME OF MOTHER

Mary Bludor

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore MD

14

Informant (Address)

15

MAR 6 - 1922

J. W. Kohn

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 4 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 27<sup>th</sup>, 1922, to March 4<sup>th</sup>, 1922

that I last saw him alive on March 4<sup>th</sup>, 1922

and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH\* was as follows:

Dysentery (Flexner)

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Stool Culture -

(Signed) Horace G. Stewart, M. D.

3/5, 1922 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer

May 7 1922

20 UNDERTAKER

ADDRESS

Paul Erickson

7706 E. Howard



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 61999

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2422 Wilkins ST., 70 WARD)

2-FULL NAME *Carlina R. Hartmann*

(a) RESIDENCE NO. 2422 Wilkins ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *April 2nd 1920*

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto. Md*

10 NAME OF FATHER *Carl Hartmann*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*

12 MOTHER *Anna Hartmann*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto. Md*

14 Informant *Carl Hartmann* (Address) *2422 Wilkins St. Balto. Md*

15 *MAR 6 - 1922* *ROBERT R. KRAUTER* Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 5 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Mar 4 1922*, to *Mar 5 1922*, that I last saw him alive on *Mar 4 1922*, and that death occurred, on the date stated above, at *7:30 a. m.*

The CAUSE OF DEATH\* was as follows:

*Coronary*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *James H. [Signature]* M. D. 3/5, 1922 (Address) *17297 [Address]*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*London Park Cemetery Mar 7, 1922*

UNDERTAKER

ADDRESS

*W. J. [Signature]*

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name organ; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Cause unknown.*  
*No gastroenteritis.*



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 62000 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *16* WARD)

2-FULL NAME

*Icey Barnes*

(a) RESIDENCE. NO.

*1432 Riggs Ave.*

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

*12* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*July 24, 1896*

7 AGE

*25* Years

Months

*7*

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

*037*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*md.*

10 NAME OF FATHER

*Louis Thompson*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*md.*

12 MAIDEN NAME OF MOTHER

*Jane Collins*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*md.*

14

Informant (Address)

*Mercy Hospital Records*

15

*MAR 6 - 1922*

ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*March 4, 1922*

17

I HEREBY CERTIFY, That I attended deceased from *March 1, 1922* to *March 4, 1922* that I last saw her alive on *March 4, 1922* and that death occurred, on the date stated above, at *8 a.* m.

The CAUSE OF DEATH\* was as follows:

*Bilateral Salpingitis  
perforated right Fallopian  
Ovary*

CONTRIBUTORY

*Acute fulminant  
pelvic peritonitis*

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

*John F. Estlin, M. D.*

*Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Sykesville Md, Sykesville*

*Mar. 7 1922*

21 UNDERTAKER

*Edward Ruggold*

ADDRESS

*1463 Carey*

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62001

## CERTIFICATE OF DEATH.

31 D 62001

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 633 W Fayette ST.: 4 WARD)

2-FULL NAME Andrew P. Mueller

(a) RESIDENCE. NO. 633 W Fayette ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 10 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen M. Mueller

6 DATE OF BIRTH (month, day, and year) Sept 6 1882

7 AGE Years 39 Months 10 Days 28 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book-keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

10 NAME OF FATHER Andrew P. Mueller

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Anne Modt

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant (Address) Mr. John M. Mueller 633 W Fayette St.

15 Filed 19 MAR 8 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 23 1922, March 4 1922,

that I last saw him alive on March 3 1922,

and that death occurred, on the date stated above, at 30 P m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 10 mos. ds.

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination of Sputum

(Signed) Leonard E. Beach M. D.

, 19 (Address) 2231 St Paul St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 3/7 22

20 UNDERTAKER George W. Farley Fulton & Fayette

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 62002 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 D 62002  
CERTIFICATE OF DEATH.

1-PLACE OF DEATH  
CITY OF BALTIMORE: (No. Roland & Melrose Aves. ST. 27 WARD)  
2-FULL NAME Mary Burgess Andrews  
(a) RESIDENCE. No. Roland & Melrose Aves ST. WARD.  
(Usual place of abode)  
(If nonresident give city or town and State)  
Length of residence in city or town where death occurred 62 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)		
Female	White	Widow		
5a If married, widowed, or divorced HUSBAND of (or) WIFE of James B. Andrews				
6 DATE OF BIRTH (month, day, and year) Sept. 28, 1838				
7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	5	3	
8 OCCUPATION OF DECEASED				
(a) Trade, profession or particular kind of work None				
(b) General nature of industry, business, or establishment in which employed (or employer)				
(c) Name of employer				
9 BIRTHPLACE (city or town) Buck's Co., (State or country) Pennsylvania				
10 NAME OF FATHER Amos Burgess				
11 BIRTHPLACE OF FATHER (city or town) (State or country)				
12 MAIDEN NAME OF MOTHER Elizabeth				
13 BIRTHPLACE OF MOTHER (city or town) (State or country)				
14 Informant Mrs. Anna Andrews Thomas (Address) Roland & Melrose Aves.				

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 4, 1922

17 I HEREBY CERTIFY, That I attended deceased from March 1-1922 to March 4, 1922, that I last saw him alive on March 3, 1922, and that death occurred, on the date stated above, at 4 A. M.

The CAUSE OF DEATH\* was as follows:  
Chronic Myocarditis  
Mitral Regurgitation  
(duration) Unknown

CONTRIBUTORY (Secondary) Acute Pulmonary Edema  
(duration) yrs. - mos. 3 ds.

18 Where was disease contracted  
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs  
(Signed) M. Gibson Porter, M. D.  
3/5, 1922 Address) 422 Roland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Friends Burying Ground	3/6, 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805 N. Calvert	

15 Filed 19 ROBERT R. KRAUTER, Registrar  
MAR 6 - 1922 Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 62003

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *15* WARD)

2-FULL NAME

(a) RESIDENCE. No. *2543 N. North Ave.* ST. *15* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S. If of foreign birth?

Yrs.

Mos.

Ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Charles E. Nalls*

6 DATE OF BIRTH (month, day, and year) *Sept 11, 1879*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*42*

*5*

*21*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Housewife*

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

*Mercy Hospital Records*

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 4, 1922*

I HEREBY CERTIFY, That I attended deceased from *Feb. 4, 1922* to *March 4, 1922*

that I last saw her alive on *March 4, 1922*

and that death occurred, on the date stated above, at *1:55 a.m.*

The CAUSE OF DEATH\* was as follows:

*Pernicious Anemia*

CONTRIBUTORY (Secondary)

(duration) *3* yrs. mos. ds.

(duration) *1* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*Home*

Did an operation precede death? *No* Date of *—*

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *John J. Green* M. D.

(Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mount Olivet Cemetery*

*Mar 7 1922*

20 UNDERTAKER

*John H. Denny*

ADDRESS

*715 Light St*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62004

D 62004

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST.: 9 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dennis Kearney(a) RESIDENCE. NO. Unknown 1604 Airgraph St. WARD. 9  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Unknown5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?6 DATE OF BIRTH (month, day, and year) 18677 AGE Years 54 Months -- Days -- If LESS than 1 day, hrs. -- or min. --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)14 Informant Hospital Records, (Address) Municipal Hospital15 MAR 6 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 19 2217 I HEREBY CERTIFY, That I attended deceased from March 3, 19 22, to March 3, 19 22, that I last saw him alive on March 3, 19 22, and that death occurred, on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH\* was as follows:

Cerebral tumorunknown (duration) yrs. mos. ds.CONTRIBUTORY Intra Cranial pressure (Secondary) (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of March 3, 1922Was there an autopsy? noWhat test confirmed diagnosis? X-ray + operative findings (Signed) J. H. Brumback, M. D.3/4/22 Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Vincent'sMar 7 19 22

20 UNDERTAKER

ADDRESS

J. C. Wiedefeld 947 Brumback

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62005

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1147 W. Cross St. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. 1147 W. Cross St.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Geo R. Minnick

6 DATE OF BIRTH (month, day, and year)

Mar 28-1857

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

64

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Henry L. Kendall

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Alice McArch

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Geo. R. Minnick 1147 W. Cross St.

15

MAR 6-1922

ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 4 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 3, 1922, to

March 4, 1922

that I last saw him alive on

Mar 4, 1922

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Apoplexy

CONTRIBUTORY (Secondary)

None

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

36, 1922 Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Green Mount Mar 8 1922 H. C. Windefield 914 Green Mt Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Cerebral hemorrhage*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Dec 28, 1921, to Mar 5, 1922,

that I last saw her alive on Mar 4, 1922,

and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH\* was as follows:

Congenital Pyloric Stenosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Cleo B. Mason, M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

MAR 6 - 1922

ROBERT R. KROGER, Registrar

Burial Place

Jerklen & Jerklen

1739 Eager



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62007

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

3609 Fernwood ave

ST.

WARD)

## 2-FULL NAME

Carolina Ermer

(a) RESIDENCE. No.

3609 Fernwood ave

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 7 mos. 9 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John Ermer

6 DATE OF BIRTH (month, day, and year)

July 24-1855

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

66

7

9

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md

10 NAME OF FATHER

Adam Lang

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany.

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Not known

14

Informant (Address)

John Ermer  
3609 Fernwood ave

MAR 6-1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Jan 10<sup>th</sup> 1922, to March 5<sup>th</sup> 1922, that I last saw her alive on March 5<sup>th</sup> 1922.

and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH\* was as follows:

Apoplexy

(duration) yrs. 1 mos. 20 ds.

CONTINUITY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed)

J. J. Jones, M. D.

3/6/1922 Address) 1011 S. Ellwood ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Int. Carmel

Mar. 8 1922

20 UNDERTAKER

Zirkler + Zirkler

ADDRESS 1738

Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 62008

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62008

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1831 N Hope ST.; 9 WARD)

REGISTERED No. C \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1831 N Hope St. 9 yrs. 1 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, married  
(Write the word.)

6-DATE OF BIRTH, Feb 4, 1858  
(Month) (Day) (Year)

7-AGE, 64 yrs. 1 mos. — ds. If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, Grinder + Polisher  
(b) General nature of industry, business, or establishment in which employed (or employer), 086

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.  
10-NAME OF FATHER, Henry Schaal  
11-BIRTHPLACE OF FATHER (State or Country), Germany  
12-MAIDEN NAME OF MOTHER, Annie Gude  
13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ann Schaal

(Address) 1831 N Hope St

15-MAR 6 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 4, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1, 1919, to Mar 4, 1922, that I saw him alive on Mar 4, 1922, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis and  
Myocard Regurgitation  
(Duration) 3 yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Toxemia

(Signed) Geo S. McKie M. D.  
Mar 6, 1922 (Address) North Park

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore DATE OF BURIAL, Mar 7, 1922

20-UNDERTAKER, Geo J. Leach ADDRESS, North Park

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62009

## CERTIFICATE OF DEATH.

D 62009

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1732 Friendstun*ST.: *15* WARD)

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *James R. Santmyer*(a) RESIDENCE NO. *1732 Friendstun*

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *29* yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Male White Married*5a If married, widowed, or divorced HUSBAND of (or) *Widowed*6 DATE OF BIRTH (month, day, and year) *Sept - 3 - 1871*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*50- 6 1*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

*I am a Santmyer 1732 Friendstun*

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 4th 1922*

17

I HEREBY CERTIFY, That I attended deceased from *November 25, 1921* to *March 4th, 1922*, that I last saw him alive on *March 4th, 1922*, and that death occurred, on the date stated above, at *7:50 P. M.*

The CAUSE OF DEATH\* was as follows:

*Chronic myocarditis.*

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

3/5, 1922 Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Woodlawn.**3-7 1922*

20 UNDERTAKER

ADDRESS

*Mrs. Chas. A. & Ralphe W. Arlington*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62010

## CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

Baltimore Md.

CITY OF BALTIMORE: (No.

304 N. Stricker St.

ST.:

WARD) 19

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Annie May

(Residence in Baltimore: No.

304 N. Stricker St.

St.; 66 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

Married

6-DATE OF BIRTH,

Feb

3

1856

(Month)

(Day)

(Year)

7-AGE,

66

1

1

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

House Work

(b) General nature of industry, business, or establishment in which employed (or employer).

037

9-BIRTHPLACE,

(State or Country),

Baltimore Md

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Balto

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

August Moore

(Address)

304 N. Stricker St.

15-

ROBERT R. KRAUTER,

Filed

MAR 6 - 1922

Burial Permit

Registered

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March

4

1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Feb 28 1922, to March 3 1922,

that I saw her alive on March 3 1922,

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH\* was as follows:

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## Remarks

*Cerebral hemorrhage*

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

*lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

*Abortion, Cellulitis, Childbirth, Convulsions, Hamorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.*

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.

D 62011

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62011

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *544 W Lee*)ST. *22* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *544 W Lee*)St.: *67* yrs., mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widow*  
(Write the word.)

6-DATE OF BIRTH, *July 8, 1854*  
(Month) (Day) (Year)

7-AGE, *67 yrs. 7 mos. 24 ds.* If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *House Work*  
(b) General nature of industry, business, or establishment in which employed (or employer), *ooo*

9-BIRTHPLACE, (State or Country), *Baltimore Md*

10-NAME OF FATHER, *Unknown*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank Abel*(Address) *544 W Lee St*

15-

MAR 6 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *March 5, 1922*  
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *Mar 3 1922*, to *Mar 5 1922*, that I saw h<sup>e</sup>r alive on *Mar 4 1922*, and that death occurred, on the date stated above, at *1 A* m.

The CAUSE OF DEATH\* was as follows:

*Diabetes Mellitus*

(Duration) *10* yrs. mos. ds.

CONTRIBUTORY (Secondary) *Pulmonary Congestion*

(Signed) *J M Delaney* M. D.

*Mar 6 1922* (Address) *6800 Garrison St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Baltimore Cem* DATE OF BURIAL, *March 6, 1922*

20-UNDERTAKER, *E. Schlotman & Son* ADDRESS *1034*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62013 CERTIFICATE OF DEATH.

D 62013

## 1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Tyson(a) RESIDENCE. NO. 1006 Low St.ST. 5 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not recorded6 DATE OF BIRTH (month, day, and year) 18927 AGE Years 29 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) (State or country) North Carolina10 NAME OF FATHER Frank Tyson11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina12 MAIDEN NAME OF MOTHER Ella Dowdy13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina14 Informant Hospital Records (Address) H. T. H.15 Filled Robert P. Harrison, Registrar

Burial Permit Clerk.

16 DATE OF DEATH (month, day, and year) March 1, 192217 I HEREBY CERTIFY, That I attended deceased from Dec. 14, 1921, to March 1, 1922, that I last saw him alive on March 1, 1922, and that death occurred, on the date stated above, at 7.40 a.m. The CAUSE OF DEATH\* was as follows:Pulmonary tuberculosis(duration) yrs. 4 mos. ds.CONTRIBUTORY Pneumothorax (Secondary)(duration) yrs. 1 mos. ds.18 Where was disease contracted If not at place of death? UnknownDid an operation precede death? NO Date ofWas there an autopsy? NOWhat test confirmed diagnosis? Typhoid in epitum, X-ray(Signed) Francis D. Delaplane M. D.3-1-22 (Address) Municipal Tbc. Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITALMAR 5 1922

20 UNDERTAKER

ADDRESS

Commissioner Health,

MARGIN RESERVED FOR BINDING

B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

MAR 6 - 1922



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62014 CERTIFICATE OF DEATH.

31 D 62014

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (Municipal Tuberculosis Hospital) 25 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carwell Smith

(a) RESIDENCE. NO. 447 Church st.  
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not given

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE Years Months Days If LESS than 1 day. hrs. or min. 61

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

10 NAME OF FATHER Solomon Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Caroline Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records (Address) M.T.H.

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1, 1922

17 I HEREBY CERTIFY, That I attended deceased from February 3, 1922, to March 1, 1922, that I last saw him alive on March 1, 1922, and that death occurred, on the date stated above, at 4.45 p. m. The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY Pneumothorax (Secondary) (duration) yrs. 1 mos. 19 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum (Signed) Francis J. Deady, M.D. 3-2-22 (Address) Municipal Tbc. Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL Johns Hopkins Hospital MAR 4-1922

20 UNDERTAKER

Commissioner Health.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-  
TION is very important. See instructions on back of certificates.

MAR 6-1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62015

## CERTIFICATE OF DEATH.

161 D 62015

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST.: *10* WARD)

## 2-FULL NAME

(a) RESIDENCE. NO. *922 E. Chase* ST.: WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*5 Single, Married, Widowed,  
or Divorced (write the word)*Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*3/3/22*

7 AGE

Years

Months

Days

If LESS than  
1 day, 5 hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Md.*

10 NAME OF FATHER

*Andrew J. Snickler*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Md.*

12 MAIDEN NAME OF MOTHER

*Anna Schaffer*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Md.*

14

Informant  
(Address)

15

Filed

*Robert P. Harrison*

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3/3/1922*

17

I HEREBY CERTIFY, That I attended deceased from

*3/3/1922*, to *3/3/1922*

that I last saw him alive on

*3/3/1922*

and that death occurred, on the date stated above, at

*9:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Asphyxia Neonatorum*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

*No*

Date of

Was there an autopsy?

*No*

What test confirmed diagnosis?

(Signed)

*E. C. Smith*

M. D.

19 (Address)

*4706 Harford Ave*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*JOHN'S HOPKINS HOSPITAL**1922*

20 UNDERTAKER

*Commissioner Health**Mar*

ADDRESS

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

MAR 6 - 1922

MAR 6 - 1922

MAR 6 - 1922

F  
A  
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A  
D  
O

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62016

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62016

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. *Mercy Hospital* St. *18* Ward)

2-FULL NAME

(Residence in Baltimore: No. *226 N. Arlington Ave.* St. *50* yrs. *50* mos. *50* ds.)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, *Married* (Write the word.)

6-DATE OF BIRTH, *Unknown* 1..... (Month) (Day) (Year)

7-AGE, *61* yrs. *50* mos. *50* ds. If LESS than 1 day, *hrs. or min.?*

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Watchman* (b) General nature of industry, business, or establishment in which employed (or employer), *City* *062*

9-BIRTHPLACE, (State or Country), *Ireland*

PARENTS. 10-NAME OF FATHER, *Martin Cusick* 11-BIRTHPLACE OF FATHER, (State or Country), *Ireland* 12-MAIDEN NAME OF MOTHER, *Unknown* 13-BIRTHPLACE OF MOTHER, (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Martin Cusick Jr.* (Address) *226 N. Arlington Ave.*

15- *Robert P. Harrison,* 102 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Mar 4* 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY that I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.)

Thereon and from the evidence obtained by said *Inquiry* and that said deceased came to *his* death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH was as follows:

*Fracture of Skull*  
*Shot as accident*  
*Shocks* (Duration) *2 hrs* (Secondary)

CONTRIBUTORY (Secondary) *Shocks* (Duration) *2 hrs* (Signed) *Geo. Clinton Bladest* (Coroner) *Man 1978* (Address) *143 N. Broadway*

\*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death *.....* yrs. *.....* mos. *.....* ds. In the State *.....* yrs. *.....* mos. *.....* ds. Where was disease contracted, if not at place of death?

Former or usual residence *.....*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*New Cathedral Cem.* *March 8 1922*

20-UNDERTAKER, ADDRESS

*John J. Cowan Son* *801 Hollins St.*

MAR 6 1922

Remarks

Dead struck by street car at on  
about Ferguson Hill Elliott City line  
Morrison Anderson.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*,

*peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

*Abortion*, *Hemorrhage*, *Meningitis*, *Phlebitis*,  
*Cellulitis*, *Gangrene*, *Miscarriage*, *Pyemia*,  
*Childbirth*, *Gastritis*, *Necrosis*, *Septicemia*,  
*Convulsions*, *Erysipelas*, *Peritonitis*, *Tetanus*.

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved): *Suicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.



D 62017

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1028 Bennett Place ST. 18 WARD)

## 2-FULL NAME

Edward Collinson

## (a) RESIDENCE NO.

1028 Bennett Place

ST.

WARD

South River Md.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 3

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Widower

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Eliza Beard Collinson

6 DATE OF BIRTH (month, day, and year)

Mch 5 - 1848

7 AGE

Years

Months

Days

If LESS than  
1 day, .... hrs.  
or .... min.

73

4

4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Maryland

10 NAME OF FATHER

John Collinson

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Md

12 MAIDEN NAME OF MOTHER

Sarah Sewell

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md

14

Informant  
(Address)Lidie Stevens  
1028 Bennett Place

15

Robert P. Harrison

, 19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 5 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 12, 1922, to Mch 5, 1922,

that I last saw him alive on Mch 4, 1922,

and that death occurred, on the date stated above, at 755 a m.

The CAUSE OF DEATH\* was as follows:

apoplexy

(duration) yrs. 1 mos. 21 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. 1 mos. 21 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? none Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

W. E. Munn M. D.

Mch 5 1922

(Address)

1520 Hollins

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Hope Chapel, South River Md Mch 7 1922

20 UNDERTAKER

ADDRESS

John O. Mitchell 1201 W. Fayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

MAR 6 - 1922

D 62018

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62018

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 308 S. Bethel ST. 3 WARD)2-FULL NAME Kazmier. Pilch(a) RESIDENCE. NO. 308 S. Bethel ST. 3 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 11 mos. 1 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 4 - 1914

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

2111

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ind.10 NAME OF FATHER Frank Pilch

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland12 MAIDEN NAME OF MOTHER Josephine Opatowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Frank Pilch  
308 S. Bethel

15

Filed

19

Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3. 5. 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 3, 1922, to March 7, 1922, that I last saw him alive on March 4, 1922, and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH\* was as follows:

Influenza  
Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

E. J. Ward M. D.

3. 5. 1922 Address)

801 N. E. 1st St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary

19

UNDERTAKER

Wm. Frankowski 1618 Eastern

MARGIN RESERVED FOR BIRTHING. N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 6 - 1922

Burial Permit Clerk.

D 62019

## HEALTH DEPARTMENT-CITY OF BALTIMORE

D 62019

## CERTIFICATE OF DEATH

1-PLACE OF DEATH 800 W. North.  
CITY OF BALTIMORE (No. 800 W. North ST. 13 WARD)  
2-FULL NAME Agnes K. Knell  
(Residence in Baltimore: No. 800 W. North St.: 1 yrs. 8 mos. 5 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female  
4-COLOR OR RACE white  
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED child (Write the word)

6-DATE OF BIRTH June 1, 1920  
(Month) (Day) (Year)

7-AGE 1 yrs. 8 mos. 5 ds. If LESS than 1 day, hrs. or min.?

## 8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9-BIRTHPLACE  
(State or country)

city - md

## 10-NAME OF FATHER

Joseph K. Knell

11-BIRTHPLACE OF FATHER  
(State or country)

city - md

## 12-MAIDEN NAME OF MOTHER

Agnes Ragannon

13-BIRTHPLACE OF MOTHER  
(State or country)

city - md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph K. Knell  
(Address) 800 W North Ave

15.

Robert P. Harrison,

6-1922

Burial Permit Clerk. REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH March 6, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 27, 1922, to March 6, 1922, that I saw her alive on March 6, 1922, and that death occurred, on the date stated above, at 6 a m.  
The CAUSE OF DEATH\* was as follows:

Membranous Croup

Contributory (SECONDARY) Bronchopneumonia  
(Duration) yrs. 7 mos. 7 ds.

(Signed) W.B. Kibbett M.D.  
3/7/22, 191 (Address) 2220 Garrison

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.  
Where was disease contracted?  
If not at place of death?  
Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

London Park

## DATE OF BURIAL

7 Mar, 1922

## 20-UNDERTAKER

Geo. W. Little

## ADDRESS

2700 Edmond

B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of QUALITY OF PA-TION is very important. See instructions on back of certificates.

MAR 6 - 1922

Spec.—1-10-21—M&T—1500 Bks.

D 62020 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 62020

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3501 Powhattan Ave ST. 15 WARD)

2-FULL NAME Albert Augustus White

(a) RESIDENCE No 3501 Powhattan Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 8 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret White

6 DATE OF BIRTH (month, day, and year) June 13 1849

7 AGE Years 72 Months 8 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wholesale

(b) General nature of industry, business, or establishment in which employed (or employer) Baker Retail

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

10 NAME OF FATHER Geo Taylor White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Emma Arrad

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Robert V White (Address) 3501 Powhattan Ave

15 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 5 1922, to Mar 5 1922, that I last saw him alive on Mar 5 1922, and that death occurred, on the date stated above, at about 2:30 m.

The CAUSE OF DEATH\* was as follows:

Angina Pectoris

(duration) yrs. mos. ds. CONTRIBUTORY (Secondary) Slight Asthma & Indigestion

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur H. Johnson, M. D. (Address) 2806 Salisbury St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Wm. Dickson & Son North Ave



D 62021

HEALTH DEPARTMENT—CITY OF BALTIMORE D 62021

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME Mr. Raymond Galloway

(a) RESIDENCE. No. Hartsville, S. C. ST. Hartsville S. C.

(Usual place of abode)

WARD

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos. 21

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male White Widowed

5a If married, widowed, or divorced

HUSBAND of Mrs. Charlotte Galloway (Daughter)

6 DATE OF BIRTH (month, day, and year) Nov. 20, 1858

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

63

3

6

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Ex. dentist 65

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

Nahum Galloway

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

Charlotte Hudson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Robert P. Harrison,

19

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb. 13, 1922, to March 6, 1922.

that I last saw him alive on March 6, 1922.

and that death occurred, on the date stated above, at 4:45 P. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of colon; peritonitis

(duration) 1 yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Pyelitis

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) E. Sidney Burrill, M. D.

, 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mc Bee S &amp; Co

March 6 1922

20 UNDERTAKER

ADDRESS

Joseph Ahrens

221 B St.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62022

## CERTIFICATE OF DEATH.

D 62022

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *581 Pulton* ST., *17* WARD)2-FULL NAME *Henry St. Brady*(a) RESIDENCE NO. *581 Pulton* ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *53* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *✓*6 DATE OF BIRTH (month, day, and year) *1849*7 AGE *73* Years Months Days If LESS than 1 day, .... hrs. or .... min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Latimer*(b) General nature of industry, business, or establishment in which employed (or employer) *✓*(c) Name of employer *✓*9 BIRTHPLACE (city or town) (State or country) *Pa*10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Unknown*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*14 Informant (Address) *Daniel E. ... 716 ...*

15

MAR 7 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 4 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan. 21st 1922* to *March 4th 1922*that I last saw him alive on *March 3d 1922*and that death occurred, on the date stated above, at *3 P. m.*

The CAUSE OF DEATH\* was as follows:

*Broncho-pneumonia*CONTRIBUTORS (Secondary) *Inferior age* (duration) yrs. mos. ds.18 Where was disease contracted *✓*

If not at place of death?

Did an operation precede death? *No* Date of *✓*Was there an autopsy? *No*What test confirmed diagnosis? *Chloride*(Signed) *A. L. ...* M. D.19 (Address) *924 ...*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Grave*

20 UNDERTAKER

*David ...*21 ADDRESS *716 ...**Pa an*

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 62023

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 16 WARD)2-FULL NAME John Norman(a) RESIDENCE. NO. 918 N. Appleton St. ST. 16 WARD. 16  
(Usual place of abode) (If nonresident give city or town and State)Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) ?5a If married, widowed, or divorced HUSBAND of ? (or) WIFE of6 DATE OF BIRTH (month, day, and year) 18527 AGE Years 69 Months -- Days -- If LESS than 1 day, hrs. -- or min. --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 615

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina  
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown  
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)14 Informant Hospital Records,(Address) Municipal Hospital.15 Filed MAR 7 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

REGISTERED NO. 100-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 19 2217 I HEREBY CERTIFY, That I attended deceased from February 7, 1921 to March 4, 1922 that I last saw him alive on March 4, 1922 and that death occurred, on the date stated above, at 11:40 AM  
The CAUSE OF DEATH\* was as follows:Pneumonia(duration) yrs. mos. 3 ds.CONTRIBUTORY (Secondary) Latent seborrheic pneumonia(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeil M. D.3/6/1922 Address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn CemeteryDATE OF BURIAL Mar 7 192220 UNDERTAKER Wm EarlsonADDRESS 916

16  
1130  
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 62024

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 62024

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Marshall

(a) RESIDENCE. No. 312 Ottenheim St. ST. 21 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) - 18 9 6

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Moore Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Katie Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Hospital Records (Address)

MAR 7 1922 19 ROBERT R. KRAUTER Registrar  
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4 1922

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1922, to March 4, 1922, that I last saw him alive on March 4, 1922, and that death occurred, on the date stated above, at 3.15 a. m.

The CAUSE OF DEATH\* was as follows:

Intestinal obstruction (post operative).

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/2/22.

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) J. M. Lupton M. D.

, 15 (Address) University Hospital

\*State the Disease Causing Death, or in deaths from Violent Cause, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Not known

20 UNDERTAKER

David Earls

DATE OF BURIAL

Mar 7 1922

ADDRESS

916  
8a ave



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. contributory (secondary or intercurrent) affect need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" (.....), "Senile," etc.), "Dropsy," "Exhaustion," "Hemorrhage," "Inanition," "Marasmus," "Shock," "Uremia," "Weakness," etc., which do not qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Struck by railway train—accident*; *Railroad accident—wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Operated upon last summer.  
Hysterectomy performed  
for salpingitis. Probably  
gonococcus infection.  
Came to hosp't abt Mar 1st  
with intestinal obstruction.*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 62025

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 62025

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3*)

ST. *3* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *921 Iramby*

(Usual place of abode)

ST. *3* WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *30* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct 22, 1870*

7 AGE Years *51* Months *4* Days *14* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Pa.*

10 NAME OF FATHER *John Carson*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*

12 MAIDEN NAME OF MOTHER *Theresa Ropes*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14 Informant *Mercy Hospital Records* (Address)

15 *MAR 7 - 1922* ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 6, 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Feb 20, 1922* to *March 6, 1922*

that I last saw him alive on *March 6, 1922*

and that death occurred, on the date stated above, at *2 P. m.*

The CAUSE OF DEATH\* was as follows:

*Tubercular Pneumonia*

CONTRIBUTORY (Secondary)

(duration) *10 hrs.* yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Home*

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Signs & symptoms*

(Signed) *John F. Brown*, M. D.

, 13 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St Vincent's Cem* *Mar 7, 1922*

20 UNDERTAKER

ADDRESS

*Heudell Hyatt & Son* *378 Bond*

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 62026

HEALTH DEPARTMENT—CITY OF BALTIMORE

62026

CERTIFICATE OF DEATH.

11.30

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 62026

HEALTH DEPARTMENT—CITY OF BALTIMORE 62026

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1411 Ward

ST. 21

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Bernice Stewart

(a) RESIDENCE. NO. 1411 Ward

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 9 mos. —

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 13/21

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

9

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

0 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Thos. Pender

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Annabel Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Annabel Stewart 1411 Ward

15

MAR 7 - 1922

ROBERT A. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 23, 1922, to March 4, 1922, that I last saw her alive on March 4, 1922, and that death occurred, on the date stated above, at 6 P. m. The CAUSE OF DEATH\* was as follows:

Intestinal Indigestion (duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Convulsions (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Harry M. Card M. D. 3/6, 1922 (Address) 2005 W. Kellam

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Int Auburn Ct

March 7 1922

20 UNDERTAKER

ADDRESS

S. L. Brown & Son

108 W. 7th St

## D 62027 HEALTH DEPARTMENT—CITY OF BALTIMORE 62027

## CERTIFICATE (OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 S. Sharp

ST. 23 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lilly Bevan

(a) RESIDENCE. NO. 912 S. Sharp

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Fem. Colored Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Lilly Bevan

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

76 yrs.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Cambridge, Md.

10 NAME OF FATHER

Abram Styles

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Cambridge, Md.

12 MAIDEN NAME OF MOTHER

Martha Dobson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Cambridge, Md.

14 Informant (Address) Nellie Johnson (Daughter) 912 S. Sharp St.

15 Filed MAR 7 - 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 4 1922

17 I HEREBY CERTIFY, That I attended deceased from

March 2, 1922, to March 4, 1922

that I last saw him alive on March 3, 1922,

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Influenza, over

(duration) yrs. mos. 15 ds.

CONTRIBUTORY Pneumonia (Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) J. L. Shelton M. D.

3/4, 1922 Address) 203 W. Lombg. St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF INTERIAL

U.S. National Ct Mar 7 1922

20 UNDERTAKER ADDRESS

J. H. Brown &amp; Son 10816 Montg

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Lobar*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62028

D 62028

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Mersey Hospital*)

ST. *4* WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Joseph A. Cascio*

(Residence in Baltimore: No. *310 Pearl St.*)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH, *July 6, 1900*  
(Month) (Day) (Year)

7-AGE, *22* yrs. *7* mos. *27* ds. If LESS than 1 day, *hrs. or min.*

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *Fruit dealer*  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Balt City*

10-NAME OF FATHER, *Samuel Cascio*

11-BIRTHPLACE OF FATHER (State or Country), *Italy*

12-MAIDEN NAME OF MOTHER *Paula Cascio*

13-BIRTHPLACE OF MOTHER (State or Country), *Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Anthony Cascio*

(Address) *310 Pearl St.*

15-

Filed *MAR 7 - 1922*

ROBERT P. KRAUTER  
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *March 3, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) And that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:  
*bullet wound in chest from*  
*gun shot in the hands of*  
*Pietro Pambonis*  
(Duration) *a few minutes* yrs. mos. ds.

CONTRIBUTORY (Secondary) *as above*  
(Duration) yrs. mos. ds.

(Signed) *J. J. Gurnea* M. D.  
(Coroner.)

3-7, 1922 (Address) *117 Maryland*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *New Catholic Cemetery* DATE OF BURIAL, *3/7/22*

20-UNDERTAKER *George J. Ruth* ADDRESS *1735 Haford*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62029

CERTIFICATE OF DEATH.

161 D 62029

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

124 E Gettys

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Frank P Jones

(a) RESIDENCE. No.

124 E Gettys

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar 5/22

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balti Md

10 NAME OF FATHER

Frank P Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Springfield

12 MAIDEN NAME OF MOTHER

Mellie Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balti Md.

14

Informant (Address)

Mr. Frank Jones 124 E Gettys

15

MAR 7-1922

ROBERT F. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 5 1922

17

I HEREBY CERTIFY, That I attended deceased from

Mar 5 1922, to Mar 5 1922,

that I last saw him alive on Mar 5 1922,

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH\* was as follows:

Chorea with - about 6 mos past.

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Wm. S. S. S.

M. D.

, 19

(Address)

1309 High

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Pk Cem

3/7 1922

20 UNDERTAKER

ADDRESS

J. Hew M. Cully

130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

*Arthur J. Dockrins*  
D 62030 HEALTH DEPARTMENT—CITY OF BALTIMORE 62030

CERTIFICATE OF DEATH.

1-PLACE OF DEATH  
CITY OF BALTIMORE: (No. *1526* *Barter* ST. *17* WARD)

2-FULL NAME *Arthur J. Dockrins*

(a) RESIDENCE NO. *1526 Barter* ST., \_\_\_\_\_ WARD \_\_\_\_\_  
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. *4* mos. *6* ds. How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of \_\_\_\_\_ (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) *Oct 30, 1921*

7 AGE Years \_\_\_\_\_ Months *4* Days *6* If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8 OCCUPATION OF DECEASED  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Md*

10 NAME OF FATHER *William Dockrins*

11 BIRTHPLACE OF FATHER (city or town) *Maryland* (State or country) *Md*

12 MAIDEN NAME OF MOTHER *Eva Holman*

13 BIRTHPLACE OF MOTHER (city or town) *Virginia* (State or country) *Virginia*

14 Informant *William Dockrins* (Address) *1526 Barter St*

15 *MAR 7 - 1922* ROBERT R. KRAUTER, Registrar

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 6 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Mar 4*, 1922, to *Mar 5*, 1922, that I last saw him alive on *Mar 5*, 1922, and that death occurred, on the date stated above, at *6 A.* m. The CAUSE OF DEATH was as follows: *Lobar Pneumonia*

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. *5* ds.

CONTRIBUTORY (Secondary) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted if not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

(Signed) *R. G. Gant* \_\_\_\_\_, M. D.

*Mar 6, 1922* (Address) *1524 E. H. Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Laurel cemetery* DATE OF BURIAL *Mar 7 1922*

20 UNDERTAKER *Milton Davis* ADDRESS *315 N Eden St*



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-22—H. P. Co.—1000 Bks.

D 62031

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 62031

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 101-001 ST.: 5 WARD)

2-FULL NAME

(a) RESIDENCE. No. 1129 E. Lexington St.

(Usual place of abode)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 17<sup>th</sup> 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

11

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

George Gounaris

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Greece

12 MAIDEN NAME OF MOTHER

Sergersa Neapoulis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Greece

14

Informant (Address)

15

MAR 7 - 1922

ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 6<sup>th</sup> 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 28<sup>th</sup>, 1922, to March 6<sup>th</sup>, 1922,

that I last saw him alive on March 6<sup>th</sup>, 1922,

and that death occurred, on the date stated above, at 2<sup>30</sup> P. M.

The CAUSE OF DEATH\* was as follows:

Pneumonia, Lobar

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Pneumothorax Empyema

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

X Ray

(Signed) Horace G. Stewart, M. D.

3/6, 1922 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cemetery

March 7 1922

20 UNDERTAKER

ADDRESS

H. E. Hughes 4401 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62032

CERTIFICATE OF DEATH.

31 D 62032

1-PLACE OF DEATH

John Hopkins Hosp

REGISTERED NO.

CITY OF BALTIMORE: No.

824 S. Charles

ST.

22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Alma Hancock

(a) RESIDENCE. NO.

824 S. Charles

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

unknown

How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct. 17<sup>th</sup> 1918

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3

4

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

chill

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

John Hancock

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

May Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

MAR 7 - 1922

ROBERT K. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 5<sup>th</sup> 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 2<sup>nd</sup> 1922, to March 5<sup>th</sup> 1922,

that I last saw her alive on March 5<sup>th</sup> 1922,

and that death occurred, on the date stated above, at 1<sup>10</sup> P. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Tuberculous meningitis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

Smear, sputum

(Signed) Horace G. Stewart, M. D.

36, 1922 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cemetery

Mar 7 1922

20 UNDERTAKER

F. A. Tracey & Son

ADDRESS

763 Hanover

N. B. — WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bka.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62033

## CERTIFICATE OF DEATH.

101-001 D 62033

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2686 Dulaney ST. 70 WARD)

2-FULL NAME Maud C. Macneal

(a) RESIDENCE No. 2686 Dulaney ST., 70 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles W. Macneal

6 DATE OF BIRTH (month, day, and year) Jan 15-1884

7 AGE Years 38 Months 1 Days 19 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)

10 NAME OF FATHER Benjamin G. Young

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Florence Riehl

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Charles W. Macneal (Address) 2686 Dulaney

15 MAR 7-1922 ROBERT R. KRAUTER

Burial Permit Clerk.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 1 1922 to Mar 4 1922 that I last saw him alive on Mar 4 1922

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopically

(Signed) R. R. Campbell M. D.

(Address) 1644 Hancock

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Western Cemetery

20 UNDERTAKER

F. R. France & Son

DATE OF BURIAL

Mar 7 1922

ADDRESS

7037 Hancock

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Hls.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62034

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1238 Aisquith ST. 10 WARD)

2-FULL NAME Rudolph C. V. Munchow

(a) RESIDENCE No. 1238 Aisquith ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 18 1854

7 AGE Years 68 Months Days If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Munchow (Address) 1238 Aisquith St.

15 MAR 7 - 1922 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1922

17 I HEREBY CERTIFY That I attended deceased from March 3 1922 to March 6 1922 that I last saw him alive on March 6 1922

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic nephritis

CONTRIBUTORY (Secondary) (duration) ? yrs. mos. ds. Uremia

18 Where was disease contracted (if not at place of death?)

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phosphorus Deficiency

(Signed) J. Mc Carver M. D.

(Address) 1114 H St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

Baltimore March 9 1922

20 UNDERTAKER ADDRESS

William Cook 502 E North Ave



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

15-4044  
D 62035

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62035

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs. Mary Sherlin  
881 Greenmount Ave City

(a) RESIDENCE. NO.

(Usual place of abode)

WARD.

Length of residence in city or town where death occurred

Yrs.

Mos.

ds.

How long in U. S., if of foreign birth

Yrs.

Mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White Married

5a If married, widowed, or divorced

(or) WIFE of

Patrick Sherlin, Husband

6 DATE OF BIRTH (month, day, and year)

Dec. 10, 1866

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

55

R

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Charwoman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

Thomas Cushin

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary Mahoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

15

MAR 7 - 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 6, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 23, 1922 to March 6, 1922

that I last saw her alive on March 6, 1922

and that death occurred, on the date stated above, at 4:40 P.M.

The CAUSE OF DEATH\* was as follows:

Cerebral haemorrhage

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

Arterio-sclerosis & hypertension

(duration) 2 yrs. - mos. - ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) C. Sidney Burrill, M. D.

. 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Catholic Cem

3/9 1922

20 UNDERTAKER

ADDRESS

William Cook

502 E North

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 62036

D 62036

CERTIFICATE OF DEATH.

129  
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 915-*Farm*

ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

*Sarah Green*

(a) RESIDENCE NO.

915-*Farm*

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

7 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*F.*

4 COLOR OR RACE

*W.*

5 Single, Married, Widowed, or Divorced, (write the word)

*Widow*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

*James Green*

6 DATE OF BIRTH (month, day, and year)

*Dec 15-1859*

7 AGE

Years

Months

Days

LESS than  
1 day, hrs.  
or min.

*62*

*2*

*19*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

*Pa.*

10 NAME OF FATHER

*Robert Callan*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Pa.*

12 MAIDEN NAME OF MOTHER

*Ann O'Brien*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Wisc.-Iowa*

14

Informant  
(Address)

*Frederick H. Green*  
*915-Farm*

15

*MAR 7-1922*

*ROBERT R. KRAUTER*

Burial Permit Check

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*March 6 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 28*, 1922, to *March 6*, 1922.

that I last saw her alive on *Feb 28*, 1922.

and that death occurred, on the date stated above, at *4:15 A. M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Interstitial  
nephritis*

(duration) *several* yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Pl. Perone etc.*

(Signed) *Ben. Rushen*, M. D.

*3-6-1922* (Address) *11804 Constan Pl*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*St. Paul's*

DATE OF BURIAL

*March 8 1922*

20 UNDERTAKER

*Wm. C. Calk*

ADDRESS

*St. Paul's*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62037  
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

31 D 62037  
REGISTERED NO.

CITY OF BALTIMORE: (No. 8 E. Belvidere Ave. ST. 27 WARD)

2-FULL NAME

Charles W. Olcott

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

8 E. Belvedere

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

5

Yrs.

mos.

ds.

How long in U. S., if of foreign birth?

Yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) ~~Widow~~

Mayme Olcott

6 DATE OF BIRTH (month, day, and year)

Unknown 3/1/80

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

41

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Machinist 631

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

N. Y.

10 NAME OF FATHER

William Olcott

11 BIRTHPLACE OF FATHER (city or town) (State or country)

N. Y.

12 MAIDEN NAME OF MOTHER

Cora Stafford

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

N. Y.

14

Informant (Address)

Mayme Olcott 8 E. Belvedere Ave

15

MAR 7 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 5, 1922 to March 5, 1922

that I last saw him alive on March 5, 1922.

and that death occurred, on the date stated above, at 9:45 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Phthisis

(duration) Several years - ds.

CONTRIBUTORY (Secondary)

Hemorrhage from lungs

(duration) Several hours - ds.

18 Where was disease contracted

if not at place of death? unknown

Did an operation precede death?

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

none

(Signed)

G. H. Buckley

M. D.

, 19

(Address) 126 W Belvidere Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Druid Ridge Cemt

3-15-22

20 UNDERTAKER

ADDRESS

William Cook

502 E. North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62038

## CERTIFICATE OF DEATH.

90 D 62038

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 Race ST. 73 WARD)

2-FULL NAME Charles Hipchen

(a) RESIDENCE. No. 1607 Race ST. 73 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Hipchen

6 DATE OF BIRTH (month, day, and year) Unknown 1850

7 AGE Years 72 Months Days If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John Hipchen (Address) 1625 Race

15 Filed MAR 7 - 1922 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1922, to Mar 5, 1922, that I last saw him alive on Mar 5, 1922, and that death occurred, on the date stated above, at 5-P. M.

The CAUSE OF DEATH\* was as follows:

Mitral Insufficiency

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds. 2

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. R. Campbell, M. D. (Address) 1644 Danvers St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery DATE OF BURIAL 3/8 1922

20 UNDERTAKER William Cook ADDRESS 502 E North St.



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62039

CERTIFICATE OF DEATH.

129 D 62039

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *114 S. Carey* ST., *19* WARD)

2. FULL NAME *Ellen F. Hickman*

(a) RESIDENCE NO. *114 S. Carey* ST., \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *61* yrs. — *15* mos. — *15* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) *Oct. 19, 1861*

7 AGE Years *61* Months *15* Days *15* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *house duties*

(b) General nature of industry, business, or establishment in which employed (or employer) *000*

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country)

10 NAME OF FATHER *Emmanuel Hickman*

11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country)

12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_ (State or country)

14 Informant *Jos. D. Gibney* (Address) *1201 W. Fayette St.*

15 *MAR 7 - 1922* ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/6/22* 19

17 I HEREBY CERTIFY, That I attended deceased from *9/22*, 19*21*, to *3/6/22*, 19, that I last saw her alive on *5/6/21*, 19

and that death occurred, on the date stated above, at *8:50 p. m.*

The CAUSE OF DEATH\* was as follows:

*Cardiac failure*

(duration) yrs. mos. *5* ds.

CONTRIBUTORY *Ch. Art. Nephritis* (Secondary)

(duration) *2* yrs. mos. ds.

18 Where was disease contracted \_\_\_\_\_ if not at place of death?

Did an operation precede death? *No* Date of \_\_\_\_\_

Was there an autopsy? *No*

What test confirmed diagnosis? *No*

(Signed) *J. M. Mump* M. D.

*3/7, 1922* (Address) *1302 W. Lombard St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL *Louisa Park* DATE OF BURIAL *March 8, 1922*

20 UNDERTAKER *John O. Mitchell* ADDRESS *1201 W. Fayette St.*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62040

CERTIFICATE OF DEATH.

D 62040

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 113 E. Clement ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy M. Belsky

(a) RESIDENCE. NO. 113 E. Clement ST., 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 10, 1921

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER James J. Belsky

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Julia Bolton

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

MAR 7 - 1922

ROBERT A. KRAUTER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 6 1922

17

I HEREBY CERTIFY, That I attended deceased from Mar 1, 1922, to Mar 6, 1922,

that I last saw him alive on Mar 5, 1922,

and that death occurred, on the date stated above, at 4 A. M.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) R. P. Campbell, M. D.

1922 Address 1644 Lombard St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Louder Park Cem

March 7, 1922

20 UNDERTAKER

ADDRESS

Mrs J. E. Evans 1428 E. Charles

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62041

REGISTERED No. C

D 62041

### 1-PLACE OF DEATH

CITY OF BALTIMORE (No. ....)

### 2-FULL NAME

(Residence in Baltimore: No. ....)

ST. .... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

#### 3-SEX.

#### 4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

#### 6-DATE OF BIRTH,

#### 7-AGE,

If LESS than 1 day, .... hrs. or .... min.?

#### 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. ....  
(b) General nature of industry, business, or establishment in which employed (or employer) .....

#### 9-BIRTHPLACE, (State or Country),

#### 10-NAME OF FATHER,

#### 11-BIRTHPLACE OF FATHER (State or Country),

#### 12-MAIDEN NAME OF MOTHER

#### 13-BIRTHPLACE OF MOTHER (State or Country),

#### 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

#### 15-

MAR 7 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

### CORONER'S CERTIFICATE OF DEATH.

#### 16-DATE OF DEATH,

(Month) (Day) (Year)

#### 17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) and that said deceased came to ... death on the day stated above.

#### The CAUSE OF DEATH\* was as follows:

#### CONTRIBUTORY (Secondary)

(Duration) .... yrs. .... mos. .... ds.

#### (Signed) .....

(Coroner.)

1017 (Address) .....

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

#### 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

#### Former or usual residence .....

#### 19-PLACE OF BURIAL OR REMOVAL,

#### DATE OF BURIAL,

#### 20-UNDERTAKER

#### ADDRESS



D 62042 HEALTH DEPARTMENT—CITY OF BALTIMORE 62042

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 838 W Pratt ST. 18 WARD)

2-FULL NAME Miss Elizabeth Godfrey

(a) RESIDENCE. NO. 838 W Pratt ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE 70 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland (State or country)

10 NAME OF FATHER Wm Godfrey

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Cath Minor

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Miss Godfrey, during life (Address) 838 W Pratt

15 MAR 7 - 1922 ROBERT H. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3. 6 1922

17 I HEREBY CERTIFY, That I attended deceased from 2. 17, 1922, to 3. 6, 1922, that I last saw her alive on 3. 6, 1922,

and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH\* was as follows:

Myocarditis (duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Legrippe (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. J. Lurlingston, M. D.

3. 6 1922 (Address) 102 E Fort Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

New Cathedral Cem March 9 1922

20 UNDERTAKER ADDRESS

John Howan &amp; Son 901 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Chronic myocarditis.*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62043

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. Veterans Hospital #56  
Ft. McHenry, Md..

REGISTERED NO.  
(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

CITY OF BALTIMORE: (No. ST. WARD)

2-FULL NAME James Baker

(a) RESIDENCE NO. None ST. WARD  
(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
26 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown  
(State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown  
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)

14 Informant E. T. Rosenbrock  
(Address) Registrar

15 MAR 7 - 1922 ROBERT A. KRAUTER,  
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5, 1922

17 I HEREBY CERTIFY, That I attended deceased from  
Feb. 22, 1922 to March 5, 1922,  
that I last saw him alive on March 5, 1922,  
and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH\* was as follows:  
Tuberculous Meningitis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY Tuberculosis chronic pul.  
(Secondary) mod. adv & active

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted Unknown  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory Test

(Signed) F. N. Gordon Surgeon (R), M. D.

3/6, 1922 (Address) Ft. McHenry, Md..

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Laurel Cemetery

DATE OF BURIAL

20 UNDERTAKER S. Quinson & Bro

ADDRESS 1127 E. Baltage

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62044

## CERTIFICATE OF DEATH.

1790 62044

### 1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Staples Hospital*)

### 2-FULL NAME

(Residence in Baltimore: No. *1010 Ashland Ave*)

### REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

#### 3-SEX

*Male*

#### 4-COLOR OR RACE

*cal*

#### 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED

*Single*  
(Write the word.)

#### 6-DATE OF BIRTH

*Mar 10 1889*  
(Month) (Day) (Year)

#### 7-AGE

*33* yrs. *3* mos. *3* ds.

#### IF LESS than 1 day,

hrs. or min.?

#### 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

*Walter Jones*

#### 9-BIRTHPLACE, (State or Country),

*Balts.*

#### 10-NAME OF FATHER,

*Robert H Jones*

#### 11-BIRTHPLACE OF FATHER (State or Country),

*md.*

#### 12-MAIDEN NAME OF MOTHER

*Jennie Jones*

#### 13-BIRTHPLACE OF MOTHER (State or Country),

*md.*

#### 14-THE ABOVE, IS TRUE TO THE BEST OF MY KNOWLEDGE,

(Informant) *Clifton Jones*

(Address) *904 1/2 E. Baltimore St*

#### 15-

*MAR 7 - 1922*

*J. E. McPherson*

Registrar.

### CORONER'S CERTIFICATE OF DEATH.

#### 16-DATE OF DEATH,

*Mar 4 1922*  
(Month) (Day) (Year)

#### 17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereof and from the evidence obtained by said (Inquest, au-

topsy and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

*Chorea & Intestinal Nephritis*

(Duration) yrs. mos. ds.

#### CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. E. McPherson* M. D.  
(Coroner.)

*3-5-1922* (Address) *191 E. Baltimore St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

#### 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

#### Former or usual residence.....

#### 19-PLACE OF BURIAL OR REMOVAL,

#### DATE OF BURIAL,

*Emt Auburn cemetery*

*Mar 7 1922*

#### 20-UNDERTAKER

#### ADDRESS

*J. E. McPherson*

*1741 E. Baltimore St*



MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-12 H. B. C. 1000 Bk

D 62045

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

174 D 62045

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2113 E. Eager* ST.: *7* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *2113 E. Eager* ST.: *7* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *80* yrs. *2* mos. *0* ds.

How long in U. S., if of foreign birth? *80* yrs. *2* mos. *0* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, Divorced (write the word) *Widowed*

5a If married, widowed, or divorced, HUSBAND of *Late Louisa Woolen*

6 DATE OF BIRTH (month, day, and year) *Jan 6 - 42*

7 AGE Years *80* Months *2* Days *0* If LESS than 1 day, hrs. *0* or min. *0*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Night Watchman*

(b) General nature of industry, business, or establishment in which employed (or employer) *A. S. Abell Co.*

(c) Name of employer *A. S. Abell Co.*

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Md*

10 NAME OF FATHER *Mr Woolen*

11 BIRTHPLACE OF FATHER (city or town) *Md* (State or country) *Md*

12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town) *Md* (State or country) *Md*

14 Informant *Rose Gray* (Address) *2113 E. Eager St.*

15 Registrar *LL* MAR 7 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/5* 19 *22*

17 I HEREBY CERTIFY, That I attended deceased from *Feb 28*, 19 *22*, at *her* *residence*, 19 *22*, that I last saw him alive on *3-6-22* at *3:30 P.* and that death occurred, on the date stated above, at *3:30 P.* The CAUSE OF DEATH\* was as follows:

*Utterly Asphyxiated*  
*Exhaustion, Hypertension*  
(duration) *1* yrs. *2* mos. *0* ds.

CONTRIBUTORY (Secondary) *Acute Edema of Lungs* (duration) *1* yrs. *2* mos. *0* ds.

18 Where was disease contracted *unknown* If not at place of death?

Did an operation precede death? *No* Date of *Feb 28*

Was there an autopsy? *No*

What test confirmed diagnosis? *findings*

(Signed) *J. M. Gray* M. D.

(Address) *3-6 22 2000 North Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Balto Cem.* DATE OF BURIAL *3/8* 19 *22*

20 UNDERTAKER *Philip Herwig* ADDRESS *2016 Orleans*

D 62046

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62046

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO

ST.:

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE, NO.

ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

35 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

38 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Bessie Berkowitz

6 DATE OF BIRTH (month, day, and year)

1858

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

64

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Grocery

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant

(Address)

15

MAR 7 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 6 22

17

I HEREBY CERTIFY, That I attended deceased from

March 5 1922, to March 6 1922.

that I last saw him alive on March 6, 1922.

and that death occurred, on the date stated above, at 4:20 P.M.

The CAUSE OF DEATH\* was as follows:

Meningitis (Pneumococcus) type

(duration) yrs. 48 mos. ds.

CONTRIBUTORY

(Secondary)

failure

(duration) yrs. 12 hrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Home

Did an operation precede death?

no March 6 1922

Was there an autopsy?

yes

What test confirmed diagnosis?

Smear, Stain, &amp; Culture

(Signed)

John J. Brown, M.D.

19 (Address)

Mercy Hospital

\*State the Disease Causing Death, or in Deaths from Violent Causes,

state (1) Means and Nature of Injury, and (2) whether Accidental,

Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

3/7 1922

Hebrew Rosedale

Such Lewis, 139 E. Pratt

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62047

## CERTIFICATE OF DEATH.

41 D 62047

1-PLACE OF DEATH

St. Agnes Hosp.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.: 1 WARD)

2-FULL NAME

Florence Feinberg

(a) RESIDENCE. No.

2201 East Balt. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life

yrs.

mos.

ds.

How long in U. S., if of foreign birth

Life

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

Wh

5 Single, Married, Widowed, or Divorced (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year)

Oct 22-1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

16 Months

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md

10 NAME OF FATHER

Hyman Feinberg

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Mary Core

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Orange, Pa

14

Informant (Address)

Hewitt 1439 E. Balt St

15

Filed

19

ROBERT R. KRAUTER Registrar

MAR 7-1922

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 6 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 28, 1922, to March 6, 1922,

that I last saw her alive on March 6, 1922

and that death occurred, on the date stated above, at 8:45 p.m.

The CAUSE OF DEATH was as follows:

Infected Hand & arm  
Septicemia

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Cardiac failure  
pulmonary pneumonia

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death?

Home

Did an operation precede death?

yes Date of Feb-28-22

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical

(Signed)

W.C. Caldwell

M. D.

19 (Address)

St. Agnes Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Friendship

3/8 1922

20 UNDERTAKER

ADDRESS

Jack Lewis 1408 E. Balt St

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

Dr. Caldwell referred  
Dept. to Dr. C. Coker Mad.  
72-73. who had seen  
child before being sent  
to hosp't. History of having  
stuck piece glass in hand  
source of infection.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62048

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Helms Hospital* ST.: *9th* WARD)

## 2-FULL NAME

*Baby Roy Michaelson*

## (a) RESIDENCE. No.

*244 Arguth*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*3/17/22*

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*1*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Helms Hospital*

## 10 NAME OF FATHER

*Adolf Michaelson*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Russia*

## 12 MAIDEN NAME OF MOTHER

*Jan Deulser*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*London Eng.*

## 14

Informant  
(Address)*2402 Records*

## 15

MAR 7 - 1922

ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*3/6/1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*3/5/1922* to *3/6/1922*that I last saw him alive on *3/6/1922*and that death occurred, on the date stated above, at *6:00* m.

The CAUSE OF DEATH\* was as follows:

*Asphyxia*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)*Prima Unit (7 m)*

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Julius Stocoforum*, M. D., 19 Address *Helms Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Helms Hospital**3/7/1922*

## 20 UNDERTAKER

## ADDRESS

*Jack Lewis 1439 Skates*

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62049

100-62049

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *300 Garrison Lane* ST. *20* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *300 Garrison Lane* St.; yrs. *7* mos. *7* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE

*White*

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

*Single*

6-DATE OF BIRTH,

*July 16, 1922*

(Month)

(Day)

(Year)

7-AGE,

*7 yrs. 7 mos. 7 ds.*

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*None*

9-BIRTHPLACE, (State or Country),

*Baltimore Md.*

10-NAME OF FATHER,

*Thomas J. Leek*

11-BIRTHPLACE OF FATHER (State or Country),

*Baltimore Md.*

12-MAIDEN NAME OF MOTHER

*Catherine Deak*

13-BIRTHPLACE OF MOTHER (State or Country),

*Baltimore Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Thomas Leek*

(Address)

*300 Garrison Lane*

15-

MAR 7 - 1922

101... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*March 8, 1922*

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

*March 1, 1922, to March 8, 1922,*that I saw him alive on *March 4, 1922,*and that death occurred, on the date stated above, at *8 A.* m.

The CAUSE OF DEATH\* was as follows:

*Acute Rheumatism.*

(Duration)..... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. .... mos. .... ds.

(Signed)..... M. D.

3. 7, 1922 (Address)..... *33 S. Street Ave.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. .... mos. .... ds. In the State yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

*Westminster*

DATE OF BURIAL

*Mar 7, 1922*

19-UNDERTAKER

*Gen. L. Schwan*

ADDRESS

*1111 Oak Ave.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## Remarks

*Capillary bronchitis. No other abnormal condition*

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

*lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

*Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.*

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.

D 62050

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

38 D 62050

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 12 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Hoskins(a) RESIDENCE. NO. 2828 Fox St.ST. 12 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
----------------------	-----------------------------------	---

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
<u>33</u>		<u>--</u>	<u>--</u>	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Virginia10 NAME OF FATHER Alex. Hoskins11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Virginia12 MAIDEN NAME OF MOTHER Ethel Hall13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Va14 Informant Hospital Records,  
(Address) Municipal Hospital.15 Filed MAR 7 - 1922 ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1922

17 I HEREBY CERTIFY, That I attended deceased from  
March 2, 19 22, to March 3, 19 22,  
that I last saw him alive on March 3, 19 22,  
and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia

(duration) yrs. mos. ds. 14  
CONTRIBUTORY Syphilis  
(Secondary) (duration) 15 yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. M. Neil, M. D.3/4/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Union Amity Charities 3/7/22

20 UNDERTAKER ADDRESS

Felix B. Pye, 102 E. Moultrie St.

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62051

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2738 E. Balto. ST., 6 WARD)

2-FULL NAME

Anna E. Hoeck.

(a) RESIDENCE NO.

2738 E. Balto

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

George Hoeck

6 DATE OF BIRTH (month, day, and year)

Jan 1. 1854

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

68

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Balto.

Ind.

10 NAME OF FATHER

Martin Fisher

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Elizabeth Fisher

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Germany.

14

Informant  
(Address)

George Hoeck.  
2732 E. Balto St.

15

MAR 7 - 1922

ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 5 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 10, 1918 to March 5, 1922.

that I last saw her alive on 11, 5, 1922.

and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH\* was as follows:

Chronic Bright's  
Kidney Disease

(duration) yrs. mos. ds.

CONTRIBUTORY

Valvular Heart

(Secondary)

(duration) 4 yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. P. Sauer, M. D.

(Address) 7600 E. Balto St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Most Holy Redeemer

3/8 1922

20 UNDERTAKER

ADDRESS

John A. Moran 3000 E. Balto.

D 62052 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62052

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Municipal Hosp. Bay View

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 70 WARD)

2-FULL NAME

Catherine Byrne

(a) RESIDENCE. NO.

320, E. Lombard St.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

3 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Guy Byrne

6 DATE OF BIRTH (month, day, and year)

1902

7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Casher

(b) General nature of industry, business, or establishment in which employed (or employer)

?

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pa.

10 NAME OF FATHER

Oliver Ruten

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa

12 MAIDEN NAME OF MOTHER

Anna Jiles

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa

14

Informant (Address)

Hosp. Records

15

MAR 7 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3 - 4 1922

17

I HEREBY CERTIFY, That I attended deceased from

3 - 1 1922 to 3 - 4 1922

that I last saw her alive on 3 - 4 - 1922

and that death occurred, on the date stated above, at 7:05 P.m.

The CAUSE OF DEATH\* was as follows:

Acute nephritis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY

(Secondary)

Angina

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Clyde M. Neel

M. D.

3-5, 1922 (Address) Bay View

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Newcastle, Pa.

DATE OF BURIAL

3-8-1922

20 UNDERTAKER

J. A. Moran

ADDRESS

340 E. Baltimore

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 62053

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3500 E Pratt ST., 76 WARD)

2. FULL NAME

(a) RESIDENCE No. 3500 E Pratt ST., 24 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Klingelhoefer

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE Years 68 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

10 NAME OF FATHER Schild

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Eschields

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant (Address) Mrs. Klingelhoefer 3500 E Pratt St.

15 MAR 7 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/5/1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1922, to May 5, 1922, that I last saw her alive on May 5, 1922, and that death occurred, on the date stated above, at 6:30 m.

The CAUSE OF DEATH\* was as follows:

Pneumonia Scurvy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia (duration) yrs. 9 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Scurvy, pneumonia

(Signed) Emanuel Stahn, M. D.

, 1922 (Address) 3325 Pratt St. Apt 101

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

Schwartz Cemetery 3-8 1922

20 UNDERTAKER J. A. Moran ADDRESS 3000 E. Balt. St.





Physicians should state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62055

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 Penna Ave ST., 17 WARD)

2. FULL NAME

Mary Ella Hums

(a) RESIDENCE NO. 1102 Penna Ave ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 2 mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE negro 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

James H. Hums

6 DATE OF BIRTH (month, day, and year)

7 AGE 30 Years ? Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Landlady 041

(b) General nature of industry, business, or establishment in which employed (or employer)

worked at home

(c) Name of employer

Home

9 BIRTHPLACE (city or town) (State or country)

Londonderry, Va

10 NAME OF FATHER

John Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Londonderry, Va

12 MAIDEN NAME OF MOTHER

Mary Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Londonderry, Va

14

Informant (Address)

John Carter (Brother)  
Londonderry, Va

15

MAR 7 - 1922

ROBERT H. KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 19 22

17

I HEREBY CERTIFY, That I attended deceased from Jan 18, 19 22 to March 4, 19 22 that I last saw her alive on March 3rd, 19 22

and that death occurred, on the date stated above, at 1 4 m.

The CAUSE OF DEATH\* was as follows:

Myocardial Infarction  
Broken Compensation

about (duration) yrs. 10 mos. ds.

CONTRIBUTORY

Chronic Intestinal  
Reflux (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Physician's exam  
(Signed) Walter J. Fox M. D.

, 19 (Address) 1618 W. Maryland

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt. Auburn

DATE OF BURIAL

March 7, 1922

20 UNDERTAKER

Mrs. Katie R. Williams

ADDRESS

1114 N. Senate St.



**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Non malignant as far as phy could determine.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62057

## CERTIFICATE OF DEATH.

31 D 62057

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *117 N. Schroeder* ST.: *18* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*William Whiting*

## (a) RESIDENCE. NO.

*117 N. Schroeder* ST.: *18* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life

yrs.

ds

How long in U. S., if of foreign birth?

yrs

mos.

ds

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*colored*

5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Aug. 18-1895*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*26**6**15*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Chauffeur*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Private family*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Md.*

10 NAME OF FATHER

*Frank Whiting*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Md.*

12 MAIDEN NAME OF MOTHER

*Hettie Tinsley*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Md.*

14

Informant (Address)

*Mrs. Carrie Parway (Sister) 117 N. Schroeder Street*

15

*MAR 7 - 1922*

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 6 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 24 1922* to *March 6 1922*that I last saw him alive on *March 6 1922*and that death occurred, on the date stated above, *10:50 A. M.*

The CAUSE OF DEATH\* was as follows:

*Infection*(duration) yrs. mos. *10* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *10* ds.18 Where was disease contracted? *Home as knowledge*

If not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Microscopic*(Signed) *Dr. J. H. Jones* M. D.Address *764 S. Main St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mt. Auburn Cemetery**Mar. 8 1922*

20 UNDERTAKER

ADDRESS *234**W. H. Johnson**Channing St.*

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21-M&T-1500 Eka.

D 62058

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114

D 62058

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1029 Wilcox ST., 10 WARD)

2-FULL NAME

Anna Murray

(a) RESIDENCE NO. 1029 Wilcox ST., WARD

(Usual place of abode) Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND or WIFE of James Murray

6 DATE OF BIRTH (month, day, and year) 3/5/1854

7 AGE Years 70 Months 3 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). (c) Name of employer.

9 BIRTHPLACE (city or town) Ireland (State or country)

10 NAME OF FATHER Thomas Nolan

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Anna Hughes

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant James Murray (Address) 1029 Wilcox St.

15 MAR 7 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1922, to Mar 5, 1922, that I last saw him alive on Mar 3, 1922, and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH\* was as follows: Senility

(duration) unknown mos. ds. CONTRIBUTORY (Secondary) Pseudo-politis (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. Bernard Weiss, M. D. 3/5/22 (Address) 914 E Biddle St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Cause and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cathedral Cem. 3/8/22

20 UNDERTAKER R. E. Hudspeth 914 E Biddle St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62059

## CERTIFICATE OF DEATH.

31 D 62059

## 1-PLACE OF DEATH

## REGISTERED NO.

CITY OF BALTIMORE: (NO. *Maryland Penitentiary*)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Edward Small*(a) RESIDENCE. NO. *530 Greenwillow*  
(Usual place of abode)

ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*Black*5 Single, Married, Widowed,  
or Divorced (write the word)*Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *March-12-1893*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*28**11**13*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*General 040*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)*Laborer*

(c) Name of employer

9 BIRTHPLACE (city or town) *Georgetown S.C.*  
(State or country)10 NAME OF FATHER *Thomas Small*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*South Carolina*12 MAIDEN NAME OF MOTHER *Grace Johnson*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*South Carolina*

14

Informant  
(Address)*J. A. Carter, Jr.*

15

MAR 7 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk.

19 PLACE OF DEATH

OR REMOVAL

DATE OF

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

Domestic Health

ADDRESS

70

Physicians should state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assoc.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*General tuberculosis  
Lungs, intestines  
etc.*





Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D 62061

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital:

CITY OF BALTIMORE: (No Johns Hopkins Hospital ST. 14 WARD)

2-FULL NAME Baby Powell (#1 of twins)

(a) RESIDENCE No. 1840 Pa. Ave ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) Mar. 2, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, \_\_\_\_\_ hrs. or 40 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work \_\_\_\_\_

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) Baltimore (State or country) md.

10 NAME OF FATHER Clarence Powell

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Alethia Weaver

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14

Informant (Address) Johns Hopkins Hospital

15

MAR 7 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 2, 1922

17

I HEREBY CERTIFY, That I attended deceased from Mar. 2, 1922 to Mar. 2, 1922 that I last saw him live on Mar. 2, 1922 and that death occurred, on the date stated above, at 8:25 a.m.

The CAUSE OF DEATH\* was as follows:

Prematurity

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted if not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? yes

What test confirmed diagnosis? \_\_\_\_\_

(Signed) F. H. Cothrell, M. D.

, 19 \_\_\_\_\_ (Address) Johns Hopkins Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

Commissioner Health,

ADDRESS

MAR 7 - 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62062 CERTIFICATE OF DEATH.

62062

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11-West-Chase-Street. ST. 11 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME FRANK GLOSSBRENNER TURNER

(a) RESIDENCE. No. 11-W-Chase-St. ST. 11 WARD. (Resident)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 49 yrs. 1 mos. 6 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Henrietta Bloodgood Turner

6 DATE OF BIRTH (month, day, and year) Jan-31-1873

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

49

1

6

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

Law

(c) Name of employer

(self)

9 BIRTHPLACE (city or town) (State or country)

Blacksburg  
Virginia

10 NAME OF FATHER Rev. James T. Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Franklin Co.  
Virginia

12 MAIDEN NAME OF MOTHER Josephine Glossbrenner

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Stanton  
Virginia

14 Informant Mrs. Lenore T. Binford (sister)

(Address) Ruxton, Md.

15

MAR 7 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6<sup>th</sup> 19 22

17

I HEREBY CERTIFY, That I attended deceased from Feb. 25<sup>th</sup> 19 21, to March 6<sup>th</sup> 19 22.that I last saw him alive on March 6<sup>th</sup> 19 22.and that death occurred, on the date stated above, at 7<sup>00</sup> a m.

The CAUSE OF DEATH\* was as follows:

Acute Lobar Pneumonia. (Type II)

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

Pulmonary edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs &amp; symptoms

(Signed) J. A. B. Clark

M. D.

(Address) 40 W. Biddle St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Loudon Park Cemetery

Mar-8-22 19

20 UNDERTAKER

STEWART &amp; MOWEN COMPANY

(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.

D 62063

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62063

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 N Fremont St WARD) 18

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Sadie Thompson

## (a) RESIDENCE

222 N Fremont St.

## WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Oct - 1866

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House word

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

## 10 NAME OF FATHER

Thomas B. Thompson

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

England

## 12 MAIDEN NAME OF MOTHER

Belina Aldwell

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

England

## 14

Informant (Address)

Albert F. Thompson  
222 N. Fremont Ave

## 15

Filed

19

MAY 7 - 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 192217 I HEREBY CERTIFY, That I attended deceased from May 4, 1922, to May 6, 1922 that I last saw her alive on May 5, 1922 and that death occurred, on the date stated above, at 1:30 a m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? XDid an operation precede death? no Date of XWas there an autopsy? noWhat test confirmed diagnosis? none(Signed) V. Kin Williams, M. D., 19 (Address) 601 Carrollton

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

Western  
H. B. running Son3-8-1922  
517 N  
Schneider

D 62064

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62064

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1417 North Caroline Street ST.; 8 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Catherine L. Thirlkel

## (a) RESIDENCE. NO.

1417 North Caroline

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Lifetime

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

John W.C. Thirlkel

## 6 DATE OF BIRTH (month, day, and year) Jan 16th. 1855

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

67

1

17

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

AT Home

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore

## 10 NAME OF FATHER

Charles Crane

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Ireland

## 12 MAIDEN NAME OF MOTHER

Catherine Nolan

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Ireland

14 Informant John W.C. Thirlkel  
(Address) 1417 N. Caroline Street.

## 15 Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) March 5 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

about 2 years, 19 to March 5 1922

that I last saw him alive on March 4 1922

and that death occurred, on the date stated above, at 3409 m.

The CAUSE OF DEATH\* was as follows:

Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)Dyspepsia & anemia  
(duration) yrs. mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W.S. Riley, M. D.

, 19 (Address) 1037 Baring

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cathedral Cemetery

## DATE OF BURIAL

3/8/22

## 20 UNDERTAKER

Chas. P. Waite 1180 N. Howard

## ADDRESS

1037 Baring

NAME should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S NAME should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

A7-1922

Aerial Photo Clerk.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62065

## CERTIFICATE OF DEATH.

D 62065

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3635 Chestnut Ave ST. 13 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

## (a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds.

## WARD.

(If nonresident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

M.

## 4 COLOR OR RACE

W

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Jocanna

## 6 DATE OF BIRTH (month, day, and year)

June 1848

## 7 AGE

73

Years

Months

Days

If LESS than 1 day. hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Md

## 10 NAME OF FATHER

Edward Blaggett

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

## 12 MAIDEN NAME OF MOTHER

Elizabeth Monaghan

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

## 14

Informant (Address)

Vernon Blaggett  
3635 Chestnut Ave

## 15

Filed

Robert P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 6 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb 2, 1922, to March 6, 1922

that I last saw him alive on March 6, 1922.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH\* was as follows:

Nerv. Heart - Driven

Insuff. (duration)

yrs.

mos.

ds.

## CONTRIBUTORY (Secondary)

Endo Carditis

(duration)

yrs.

mos.

ds.

## 18 Where was disease contracted if not at place of death?

No

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Physical Exam

(Signed)

Robt. Norman, M. D.

1922 Address

3637 Chestnut Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Mt. Airy Howard to March 9 1922

## 20 UNDERTAKER

## ADDRESS

Chenoweth &amp; Son Chestnut Ave

7-1922

Burial Permit Clerk.

D 62066

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62066

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *617 Dennison*)ST.: *16* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*John Clinton Logue*

## (a) RESIDENCE. NO.

*617 Dennison*

ST.,

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *63* yrs. *9* mos. *20* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*male*

## 4 COLOR OR RACE

*white*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *May 17-1858*

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*63yr**9mo**20days*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Real Estate Operator*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.*  
(State or country)10 NAME OF FATHER *Peter T. Logue.*11 BIRTHPLACE OF FATHER (city or town) *Balto Md.*  
(State or country)12 MAIDEN NAME OF MOTHER *Catherine Miller*13 BIRTHPLACE OF MOTHER (city or town) *Balto, Md.*  
(State or country)

## 14

Informant  
(Address)*Alma Schuman  
617 Dennison St*

## 15

Filed

*Robert P. Harrison,*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 7 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from  
*February 28, 1922, to March 7, 1922,*  
that I last saw him alive on *March 7, 1922,*  
and that death occurred, on the date stated above, at *11:30 A. M.*

The CAUSE OF DEATH\* was as follows:

*Broncho-Pneumonia.*(duration) — yrs. — mos. *2* ds.CONTRIBUTORY  
(Secondary)*Influenza*(duration) — yrs. — mos. *9* ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date of —Was there an autopsy? *no*What test confirmed diagnosis? *Auscultation & percussion.*(Signed) *Chester Piland,* M. D.3-7, 1922 (Address) *2532 Edmondson Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*London Park Cem.**Mar 10 1922*

## 20 UNDERTAKER

## ADDRESS

*L. W. R. Little**3700  
Edmondson*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE should be written in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

A7

-1922

Burial Permit Clerk.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*This patient also had organic heart disease. Length of time unknown.*

D 62067

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62067

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1419 Gough

ST.

WARD) 3

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Waclawa Majchrzak*

(a) RESIDENCE. No. 1419 Gough

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *June 5 1912*7 AGE Years *5* Months *9* Days *1* If LESS than 1 day. hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country)10 NAME OF FATHER *Waclaw Majchrzak*11 BIRTHPLACE OF FATHER (city or town) *Poland* (State or country)12 MAIDEN NAME OF MOTHER *Salina Jertanin*13 BIRTHPLACE OF MOTHER (city or town) *Poland* (State or country)14 Informant *Waclaw Majchrzak* (Address) *1419 Gough St*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 6 1922*

17

I HEREBY CERTIFY, That I attended deceased from *March 2*, 19 *22*, to *March 6*, 19 *22*, that I last saw him alive on *March 8*, 19 *22*, and that death occurred, on the date stated above, at *7:35 A.M.*

The CAUSE OF DEATH\* was as follows:

*Septic Endocarditis*CONTRIBUTORY (Secondary) *unresorbed Pneumonia* (duration) yrs. mos. ds.(duration) yrs. mos. ds. *21*

18 Where was disease contracted if not at place of death?

Did an operation precede death?

*no*

Date of

Was there an autopsy?

*no*

What test confirmed diagnosis?

*Clinical Exam.*

(Signed)

*A. F. Reis*, M. D.

24 S. Blumway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Holy Rosary March 8 1922*

20 UNDERTAKER ADDRESS

*John M. Weber 1803 Bank*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 7 1922

Burial Permit Clerk Registrar



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62068

## CERTIFICATE OF DEATH.

148 D 62068

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *209 S. Chapel* ST. *2* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Bozumiła Kowalska*(a) RESIDENCE. NO. *209 S. Chapel* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *15* yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female white*

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced (write the word)

*married*

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Andrew Kowalski*6 DATE OF BIRTH (month, day, and year) *May 10 1892*

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*29**9**25*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*House work*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Poland*

## 10 NAME OF FATHER

*Stanislaus Malaszczyk*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Poland*

## 12 MAIDEN NAME OF MOTHER

*Alexandra Babrowski*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Poland*

## 14

Informant  
(Address)*Mr. Andrew Kowalski  
209 S. Chapel St.*

## 15

Filed

*Robert P. Harrison*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/6* 192*2*

## 17

I HEREBY CERTIFY, That I attended deceased from

*5/6*, 19*22*, to *5/6*, 19*22*,that I last saw her alive on *5/6*, 19*22*,and that death occurred, on the date stated above, at *10 P.* m.

The CAUSE OF DEATH\* was as follows:

*Eclampsia Gravidarum*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *Philippus Artigiani*, M. D.19 (Address) *2942 E. Fayette St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Holy Rosary**March 9 1922*

## 20 UNDERTAKER

## ADDRESS

*John M. Weber 1803 Bank St.*

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MAY 7 - 1922

Burial Permit Clerk.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S STATEMENT OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of EQUIPMENT is very important. See instructions on back of certificates.

Spec. - 1-10-21 - M&T - 1500 Rk. (Samuel)

HEALTH DEPARTMENT - CITY OF BALTIMORE

D 62069

CERTIFICATE OF DEATH.

1- PLACE OF DEATH

CITY OF BALTIMORE: (No. 2100 E. Balto St. ST., 6 WARD)

2- FULL NAME Samuel Sabelovitch

(a) RESIDENCE NO. 2100 E. Balto St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

REGISTERED NO. 75-002 D 62069

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1830

7 AGE 92 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Abraham Sabelovitch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Hannah Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Mr. J. E. Pratt 2100 E. Balto St.

15 Filed Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/7 1922

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1922, to March 6, 1922, that I last saw him alive on March 6, 1922, and that death occurred, on the date stated above, at 10 A. M. The CAUSE OF DEATH\* was as follows: General paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

Signed W. J. Bay M. D.

3/7, 1922 (Address) 2100 E. Balto St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Hebrew Burial 3/7 1922

20 UNDERTAKER J. L. Linscott & Co. 1127 E. Balto St.

AR7-1922

D 62070 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

## CERTIFICATE OF DEATH.

D 62070

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2108 Huntington Ave ST., 129 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. 2108 Huntington Ave ST., 129 WARD(Usual place of abode)  
Length of residence in city or town where death occurred 38 yrs. — mos. — ds. How long in U. S., if of foreign birth? 38 yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of Mary Smith  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) May 19067 AGE Years 64 Months — Days — If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland  
(State or country)10 NAME OF FATHER James Smith11 BIRTHPLACE OF FATHER (city or town) Ireland  
(State or country)12 MAIDEN NAME OF MOTHER Mrs. Mannion13 BIRTHPLACE OF MOTHER (city or town) Ireland  
(State or country)14 Informant Mrs. Mary Smith  
(Address) 2108 Huntington Ave15 Filed MAR 8 - 1922 ROBERT R. KRAUTER, Registrar  
Bureau Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 192217 I HEREBY CERTIFY, That I attended deceased from Dec 1921 to March 7 1922, that I last saw him alive on March 7 1922, and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis(duration) 6 yrs. — mos. — ds.

## CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? Clinical(Signed) Wesley S. Bishop M. D., 19 (Address) 930 N. Calvert St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral CemeteryMarch 10 1922

20 UNDERTAKER

ADDRESS

Henry Horck1301 E. Eager St.

Physicians should state EXACTLY how death occurred. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D 62071

HEALTH DEPARTMENT—CITY OF BALTIMORE

MORE 100 62071

**CERTIFICATE OF DEATH.**

**PLACE OF DEATH**

CITY OF BALTIMORE (No

2. FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX <i>Female</i>	4-COLOR OR RACE, <i>white</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the ord.) <i>1<sup>st</sup></i>
6-DATE OF BIRTH, <i>Sept 21 1900</i> (Month) (Day) (Year)		
7-AGE, <i>13 yrs. 5 mos. 12 ds.</i>		8-LESS than 1 day, ...hrs. or...min.
9-OCCUPATION: (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		

**B-BIRTHPLACE.**  
(State or Country).

**PARENTS.**

10-NAME OF FATHER, *Arthur Gibson*

11-BIRTHPLACE OF FATHER (State or Country), *Balto*

12-MAIDEN NAME OF MOTHER, *Julia Henry*

13-BIRTHPLACE OF MOTHER (State or Country), *Ind.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15- MAR 8 - 1922 ROBERT R. KRAUTER,  
Filed....., Tol..... Burial Permit Clerk.....  
Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 5, 1972  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the  
remains described above, held an.....  
(Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said.....  
(Inquest, au  
..... and that said deceased came to..... death  
(autopsy or inquiry.)  
on the day stated above.  
THE CAUSE OF DEATH..... was as follows:

..... (Duration) ..... yrs..... mos..... da

CONTRIBUTORY.....  
(Secondary)

(Signed) John J. [Signature] (Coroner) 3-6-12 (Address) 44-22nd

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds

Where was disease contracted, if not at place of death?.....

**Former or usual residence.....**

[illegible]

<b>20-UNDERTAKER</b>	<b>ADDRESS</b>
C.B.	



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62072

## CERTIFICATE OF DEATH.

D 62072

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

## 2-FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant (Address)

## 15

Filed

MAR 8 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

## 17

I HEREBY CERTIFY, That I attended deceased from Feb. 11<sup>th</sup>, 1922, to March 3<sup>rd</sup>, 1922that I last saw him alive on March 3<sup>rd</sup>, 1922

and that death occurred, on the date stated above, at 7:20 P.M.

The CAUSE OF DEATH\* was as follows:

Early Hereditary Syphilis

(duration) yrs. 6 mos. ds.

## CONTRIBUTORY (Secondary)

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Wassermann + + +

(Signed) Elmer B. Brown, M. D.

March 19 22 (Address) Johns Hopkins Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

MAR 7 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62073

## CERTIFICATE OF DEATH.

162 D 62073

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Woman's Hospital ST., 15 WARD)

## 2-FULL NAME

Baby John M<sup>c</sup> Sweeney

## (a) RESIDENCE NO.

2219 W. Paul.

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than 1 day, 11 hrs. or 20 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

ooo

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Md

## 10 NAME OF FATHER

John J. M<sup>c</sup> Sweeney

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Mass

## 12 MAIDEN NAME OF MOTHER

Mary Hund

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

N. J.

## 14

Informant (Address)

Edmund (Address) Woman's Hospital

## 15

MAR 8-1922

GG

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) March 7 1922

17

I HEREBY CERTIFY, That I attended deceased from March 7, 1922, to March 7, 1922, that I last saw him alive on March 7, 1922, and that death occurred, on the date stated above, at 3:20 p.m.

The CAUSE OF DEATH\* was as follows:

Congenital Atelactasis

(duration) yrs. mos. 1 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Physical Exam

(Signed) Edmund M. D.

3/7, 1922 (Address) Woman's Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral

## DATE OF BURIAL

March 7, 1922

## 20 UNDERTAKER

Harry Jenkins &amp; Co

## ADDRESS

Georgetown

maison should be carefully supplied. AGE should be stated EXACTLY. PRESENT ADDRESS should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 62074 HEALTH DEPARTMENT - CITY OF BALTIMORE D 62074

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1035 N Wolfe. ST., 7 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Joseph Marshall

## (a) RESIDENCE No.

1035 N. Wolfe.

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

4 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male Colored Single

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

None

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

21

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Sparrow Point  
in Balt-City 4 years

10 NAME OF FATHER

John Marshall

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Va

12 MAIDEN NAME OF MOTHER

Bessie Holley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Va

14

Informant  
(Address)4 Brother Bessie Marshall  
1035 N Wolfe

15

MAR 8 - 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 6 - 1922

17

I HEREBY CERTIFY, That I attended deceased from

2 - 25 - 1922 to 3 - 6 - 1922

that I last saw him alive on 3 - 6 - 1922

and that death occurred, on the date stated above, at 4.00 A.M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed) W. H. Gargill, M. D.

3-7, 1922 (Address) 611 N. Caroline

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

Ashbury Cemetery  
Mrs R A Elliott

ADDRESS 1728

Ashland

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 10 WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

ds.

How long in U. S., if of foreign birth?

(If nonresident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, ..... hrs.  
or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

MAR 8 - 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 6<sup>th</sup> 1922

17

HEREBY CERTIFY, That I attended deceased from Feb. 27<sup>th</sup>, 1922, to Mar. 6<sup>th</sup>, 1922that I last saw him alive on Mar. 6<sup>th</sup>, 1922,and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia, lobarCONTRIBUTORY (duration) ..... yrs. .... mos. 10 ds.  
(Secondary) Pneumococcus meningitis(duration) ..... yrs. .... mos. 1 ds.18 Where was disease contracted  
if not at place of death? HomeDid an operation precede death? No Date of .....Was there an autopsy? YesWhat test confirmed diagnosis? Lumbar Puncture(Signed) Horace G. Stewart, M. D.77. 19 (Address) Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laural CemeteryMarch 8 1922

20 UNDERTAKER

ADDRESS 1725Mrs Robert A. ElliottAshlandAv

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.



N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

D 62077

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Duration)

yrs.

mos.

ds.

(Duration)

yrs.

mos.

ds.

(Signed)

(Coroner.)

M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

D 62076

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

D 62076

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital WARD) 5

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Wright(a) RESIDENCE. NO. 261 Colvin st.  
(Usual place of abode)ST. Unknown WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widower5a If married, widowed, or divorced  
HUSBAND of Not stated  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18717 AGE 50 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) born in Balt-10 years  
(State or country) South Carolina10 NAME OF FATHER John Wright11 BIRTHPLACE OF FATHER (city or town) South Carolina  
(State or country)12 MAIDEN NAME OF MOTHER Perchie Bridges13 BIRTHPLACE OF MOTHER (city or town) South Carolina  
(State or country)14 Informant Hospital Records  
(Address) M.T.H.15 Filed 19 Registrar Gey

MAR 8 - 1922

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6, 192217 I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1921, to March 6, 1922,  
that I last saw him alive on March 5, 1922.and that death occurred, on the date stated above, at 7.30 A. m.  
The CAUSE OF DEATH\* was as follows:Pulmonary tuberculosis(duration) yrs. 9 mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. in sputum, X-ray(Signed) Francis D'Adaglio M. D.3-6-22 (Address) Municipal Tbc. Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Laurel Cemetery

## DATE OF BURIAL

March 10, 1922

## 20 UNDERTAKER

Mr Robert A Elliott

## ADDRESS

1721  
Oakland  
A4Exact statement of OCCUR-  
rence should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.  
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.  
TION is very important.

Every item of information should be carefully supplied. Age should be stated in plain terms. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

*Herbert Gurell*  
D 62078 HEALTH DEPARTMENT - CITY OF BALTIMORE D 62078  
1917

CERTIFICATE OF DEATH.

1-PLACE OF DEATH  
CITY OF BALTIMORE (No. *1595 Hospital* ST. *7* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
2-FULL NAME *Herbert Gurell*  
(Residence in Baltimore: No. *622 in Central Ave* St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>Male</i>	4-COLOR OR RACE. <i>Cal</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <i>Single</i> (Write the word.)
6-DATE OF BIRTH, ....., 1..... (Month) (Day) (Year)		
7-AGE, <i>26</i> yrs..... mos..... da. If LESS than 1 day, .... hrs. or .... min.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer)..... <i>Labany</i>		
9-BIRTHPLACE, (State or Country), <i>live in Balt 6 years</i> <i>Balt</i>		
PARENTS.	10-NAME OF FATHER, <i>Gray Gurell</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>Balt</i>	
	12-MAIDEN NAME OF MOTHER <i>Mar Jeffers</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Balt</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) *Geo. Palmer*  
(Address) *425 Central*

15-  
F1 MAR 8 - 1922 191. ROBERT R. KRAUTER, Registrar.  
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Mar 6*, 19*17*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....  
(Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said.....  
(Inquest, autopsy or inquiry.)  
and that said deceased came to..... death on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
*Shot*  
*Shot* (Duration)..... yrs..... mos..... da.  
CONTRIBUTORY (Secondary).....  
(Duration)..... yrs..... mos..... da.  
(Signed) *R. M. Gurell* D. (Coroner.)  
*38* (Address) *425 Central*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).  
At place of death..... yrs..... mos..... da. In the State..... yrs..... mos..... da.  
Where was disease contracted, if not at place of death?.....  
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Thelma North Carolina* DATE OF BURIAL, *March 8 1917*  
20-UNDERTAKER, *Mrs Robert A Elliott* ADDRESS *1725 - Highland Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62079

D 62079

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1917 W Pratt, ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Charles F. Schiek

(a) RESIDENCE. No. 1917 W. Pratt, ST. WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

How long in U. S., if of foreign birth? 70 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Katharine Schiek

6 DATE OF BIRTH (month, day, and year)

Feb. 14, 1832

7 AGE

90

Months

0

Days

19

LESS than 1 day, hrs.

or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

retired 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

George Schiek

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant

(Address)

Miss Kate Schiek

1917 W Pratt

15

File

MAR 8 - 1922

ROBERT R. KNAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/5 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov 1 - 1921 to Mar 5 - 1922

that I last saw him alive on Mar 5 - 1922

and that death occurred, on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis  
Senility

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical diagnosis

(Signed)

E. Heller Kemmerly M. D.

3/4, 1922

(Address) 2000 Hollins St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Linden Park

Mar 8 1922

20 UNDERTAKER

ADDRESS

Joseph Syfer 1606 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62080

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2020 Bank ST., V WARD)

## 2-FULL NAME

Joseph Bacigalupo

## (a) RESIDENCE NO.

2020 Bank

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 6 1922

7 AGE

Years

Months

Days

If LESS than 1 day, 8 hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Joseph Bacigalupo

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt

12 MAIDEN NAME OF MOTHER

Mary Cuneo

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt

14

Informant (Address)

Joseph Bacigalupo

15

MAR 8 - 1922

Burial Permit

Burial Permit

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 6 1922

17

I HEREBY CERTIFY, That I attended deceased from March 6, 1922 to March 7, 1922 that I last saw him live on March 7, 1922 and that death occurred, on the date stated above, at 11 A. M.

The CAUSE OF DEATH\* was as follows:

Scarlet fever  
Pneumonia  
of six months.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. L. Valentino, M. D.

Address

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St Vincent

20 UNDERTAKER

Wendell Wyfelson

DATE OF BURIAL

March 1922

ADDRESS

378 N

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 62081

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 D 62081

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital 18 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter West(a) RESIDENCE. NO. 861 Raborg st.

ST.. WARD.

(Usual place of abode)  
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.  
(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widower5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Not stated6 DATE OF BIRTH (month, day, and year) 18737 AGE Years Months Days If LESS than 1 day, hrs. or min.  
49

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland10 NAME OF FATHER Joseph West11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Unknown12 MAIDEN NAME OF MOTHER Emily Chase13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Unknown14 Informant Hospital Records  
(Address) H.T.H.15 MAR 8 - 1922 ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5, 192217 I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1922, to March 5, 1922, that I last saw him alive on March 5, 1922, and that death occurred, on the date stated above, at 5.40 p. m.  
The CAUSE OF DEATH\* was as follows:Pulmonary tuberculosis(duration) 1 yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? UnknownDid an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray(Signed) Francis L. Dalaghiacca M. D.3-6-22 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 62082

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 90 D 62082

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital*)

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

*Rev. Bro. Leo Watchorn*

(a) RESIDENCE. NO.

*Amundale, Md*

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yr.

mos.

7

ds.

How long in U. S. if of foreign birth?

yr.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*March 13 1902*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*19*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Brother*

(b) General nature of industry, business, or establishment in which employed (or employer)

*— 000*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Philadelphia Pa*

10 NAME OF FATHER

*Thomas A Watchorn*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*England*

12 MAIDEN NAME OF MOTHER

*Sarah Scott*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*England*

14

Informant

(Address)

*Thomas A. Watchorn (Brother)  
3018 Coloma St Philadelphia Pa*

15

*MAR 8 - 1922*

*ROBERT R. KRAUTER,*

*Burial Permit Clerk.*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 7, 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Feb. 28, 1922*, to *March 7, 1922*, that I last saw him alive on *March 7, 1922*

and that death occurred, on the date stated above, at *11:15 P. m.*

The CAUSE OF DEATH\* was as follows:

*Pulmonary Edema*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Myocardial Infarction*

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death?

*No*

Was there an autopsy?

*No*

What test confirmed diagnosis?

(Signed) *Herman J. Dorf*, M. D.

, 19 (Address) *St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Amundale Md.*

*3-9 1922*

20 UNDERTAKER

ADDRESS

*E. B. Harle 115 E. 11th St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62083

D 62083

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Jackson(a) RESIDENCE. NO. 1936 McCullough St ST. 14 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18687 AGE Years 53 Months -- Days -- If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Co., Maryland10 NAME OF FATHER Enoch Ayers11 BIRTHPLACE OF FATHER (city or town) Maryland12 MAIDEN NAME OF MOTHER Mary Dicks13 BIRTHPLACE OF MOTHER (city or town) Maryland14 Informant Hospital Records  
(Address) Municipal Hospital15 MAR 8 - 1922 ROBERT R. KRAUTER,

Municipal Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 192217 I HEREBY CERTIFY, That I attended deceased from February 22, 1922, to March 6, 1922, that I last saw her alive on March 5, 1922, and that death occurred, on the date stated above, at 12:15 A.M.

The CAUSE OF DEATH\* was as follows:

Moist gangrene of left foot

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

3/6/1922 Address Municipal Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Probably Diabetic*  
*Operation Removal of*  
*Tooth.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 62084

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 927 Forrest ST., 10 WARD)

2. FULL NAME

(a) RESIDENCE NO. 927 Forrest ST., 10 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1/13/22

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 1 22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

10 NAME OF FATHER John Gioriel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Annie Daley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14

Informant (Address) 927 Forrest St

15 MAR 8 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/7/22

17 I HEREBY CERTIFY, That I attended deceased from

2/19, 1922, to 3/7, 1922,

that I last saw her alive on 3/6, 1922,

and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH\* was as follows:

congenital blocking of the common bile duct

(duration) life yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none except clinical

(Signed) Dr. Bernard W. H. M. D.

3/7, 1922 (Address) 914 E. Brodke St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

New-Central March 19 22  
Chas. A. Windyfield 501 E 22

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -1-10-21 - M&T - 1500 Bha.

HEALTH DEPARTMENT—CITY OF BALTIMORE **D 62085** **D 62085**  
CERTIFICATE OF DEATH. *X 100*

1. PLACE OF DEATH *Ch. & I -*  
CITY OF BALTIMORE: (No. *Broadway & Front* ST. *6* WARD)  
2. FULL NAME *Mrs. Anna Richardson -*  
(a) RESIDENCE NO. *St. Michels, Mt. St.* WARD  
(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred yrs. *1* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*  
5a If married, widowed, or divorced HUSBAND of (or) WIFE of  
6 DATE OF BIRTH (month, day, and year) *Aug 18 - 1904*  
7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*17 6 20*

8 OCCUPATION OF DECEASED  
(a) Trade, profession or particular kind of work *School girl*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Talbot Co Md.*

10 NAME OF FATHER *Frank Richardson*  
11 BIRTHPLACE OF FATHER (city or town) (State or country) *Talbot Co Md.*  
12 MAIDEN NAME OF MOTHER *Minnie Swell*  
13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Talbot Co Md.*

14 Informant *Mrs. F. Richardson*  
(Address) *Talbot Co Md.*

15 **MAR 8 - 1922** ROBERT R. KRAUTER,  
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 8, 1922*  
17 I HEREBY CERTIFY, That I attended deceased from *Feb. 22, 1922* to *March 8, 1922*.  
that I last saw her alive on *March 7, 1922*,  
and that death occurred, on the date stated above, at *2 A. M.*  
The CAUSE OF DEATH\* was as follows:  
*Endocarditis Streptococcus pyogenes*

(duration) yrs. *3* mos. *8* ds.  
CONTRIBUTORY *Pneumonia*  
(Secondary) (duration) yrs. mos. *4* da.

18 Where was disease contracted if not at place of death?  
Did an operation precede death? *No* Date of  
Was there an autopsy?

What test confirmed diagnosis *Clinical methods*  
(Signed) *W. B. Rice* M. D.  
19 (Address) *Church Home & Dispensary*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Blairmore Md.* DATE OF BURIAL *3/10 1922*

20 UNDERTAKER *S. Fero M. Bully* ADDRESS *150 E. Fort*

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62086

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 62086

1-PLACE OF DEATH

City of BALTIMORE: (No. *St Agnes Hospital* St. *1* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. *Anna M. Coster*

(Residence in Baltimore: No. *2006 E Pratt St* St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *white* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Married*

6-DATE OF BIRTH. *Dec 23* 1897 (Month) (Day) (Year)

7-AGE. *24* yrs. *2* mos. *10* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *House wife* (b) General nature of industry, business, or establishment in which employed (or employer). *037*

9-BIRTHPLACE, (State or Country). *Baltimore, Md.*

10-NAME OF FATHER. *William Hanna*

11-BIRTHPLACE OF FATHER, (State or Country). *Allegheny Co Pa.*

12-MAIDEN NAME OF MOTHER. *Anna Bick*

13-BIRTHPLACE OF MOTHER, (State or Country). *Carroll Co. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Anna Hanna*

(Address) *303 Edmondson Ave.*

15.

MAR 8 - 1922

Registrar. *LS*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Mar. 6* 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *autopsy* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *autopsy* (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows: *Septicæmia following an abortion, induced by some one unknown*

CONTRIBUTORY *acute yellow atrophy & liver & acute hepatitis* (Secondary) (Duration) yrs. mos. ds. (Signed) *James M. Denton* M. D. (Coroner.)

*near 1922* (Address) *400 E Chase St*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place *St Agnes Hos* In the of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted, if not at place of death? *unknown*

Former or usual residence *2006 E Pratt St*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *London Park Cemetery* *March 8* 1922

20-UNDERTAKER, ADDRESS *W E Hughes* *424 N Broadway*



D 62087

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62087

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3445 Fall Road ST. 13 WARD)

## 2-FULL NAME

Menella Gibson Walker

## (a) RESIDENCE. NO.

3445 Fall Road ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

40 yrs. 0 mos.

ds. How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John M Walker

6 DATE OF BIRTH (month, day, and year)

Oct 3 1887

7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

64

4

4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Co Maryland

10 NAME OF FATHER

James T. Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Co Maryland

12 MAIDEN NAME OF MOTHER

Annante Sanders

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Co Maryland

14

Informant (Address)

John M. Walker 3445 Fall Road

15

MAR 8 - 1922

Gly

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 7th 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 1919, to March 7, 1922.

that I last saw her alive on March 6, 1922.

and that death occurred, on the date stated above, at 8:15 A. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of breast.

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Metastasis of lung &amp; pleura (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

yes

Did an operation precede death?

yes

Date of Sept 1919

Was there an autopsy?

What test confirmed diagnosis? Microscopic exam

(Signed)

W. S. Marshall M. D.

, 19

(Address) 3429 Chestnut St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Loring Cemetery

Mar 9 22

20 UNDERTAKER

ADDRESS

A. S. Marshall 3539 Falls Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE **D 62088****D 62088**

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1402 N Chester ST., 8 WARD)2. FULL NAME Julia C. Keenel(a) RESIDENCE NO. 1402 N Chester ST., 8 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX A 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 19197 AGE Years Months Days If LESS than 1 day, hrs. or min. 2 10

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Docto9 BIRTHPLACE (city or town) (State or country) Docto10 NAME OF FATHER Louis Keenel11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto12 MAIDEN NAME OF MOTHER Mary A. Keenel13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14

Informant (Address) 1402 N Chester

15

Filed MAR 19-1922J. E. Keenel Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 19 2217 I HEREBY CERTIFY, That I attended deceased from Feb 16, 19 22 to March 5, 19 22 that I last saw her alive on March 5, 19 22 and that death occurred, on the date stated above, at 4:50 a.m. The CAUSE OF DEATH\* was as follows:Broncho - Pneumonia(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior*

D 62089

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62089

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1728 E Oliver ST., 8 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

(a) RESIDENCE NO. 1728 E Oliver ST., 8 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds.

How long in U. S., if of foreign birth 40 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

MAR 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 4, 1921, to Mar 7, 1922,

that I last saw her alive on Mar 7, 1922,

and that death occurred, on the date stated above, at 3:00 p.m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. 11 mos. 27 ds.

CONTRIBUTORY  
(Secondary)

(duration) 1 yrs. 11 mos. 27 ds.

18 Where was disease contracted

if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinal tests

(Signed) J. L. McDonald, M. D.

(Address) 1540 N Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS



D 62090

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62090

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2245 Wilkins ST., 70 WARD)

2-FULL NAME Louis H. Eilbacher

(a) RESIDENCE No. 2245 Wilkins Ave  
(Usual place of abode)

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male white Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Annie Eilbacher

6 DATE OF BIRTH (month, day, and year) Nov 25 - 1861

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

60

3

11

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Sergeant of Police

061

9 BIRTHPLACE (city or town)  
(State or country)

Balto

10 NAME OF FATHER John Eilbacher

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Germany

12 MAIDEN NAME OF MOTHER Bernadine Pickensberg

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Germany

14 Informant Mrs Annie Eilbacher  
(Address) 2245 Wilkins Ave

15

Filed

MAR 8 - 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3. 6, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 24, 1922, to March 6, 1922

that I last saw him alive on March 6, 1922

and that death occurred, on the date stated above, at 7.40 a. m.

The CAUSE OF DEATH\* was as follows:

Intermittent Nephritis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

Static Pneumonia

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Ora Libesche M. D.

(Address) 2565 Frederick Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral Cem

UNDERTAKER

F. A. Thompson

DATE OF BURIAL

Mar 9/22

ADDRESS

731 Avenue

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 62091 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62091

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *Little Sisters of the Poor* ST. 10 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Louis Sparrer.*(a) RESIDENCE. NO. *Creston Valley* ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *Unknown* ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*5a If married, widowed, or divorced *Widowed* HUSBAND of *Elizabeth Trostner* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *20 May 1836*7 AGE Years *85* Months *9* Days *17* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer* 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Germany* (State or country)10 NAME OF FATHER *John Sparrer*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *Barbara Franz*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant *Sister Florence* (Address) *Creston Valley, Md.*15 Filled *MAR 8 - 1922* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 7 1922*17 I HEREBY CERTIFY, That I attended deceased from *10* to *19* 19*22*that I last saw him alive on *May 6* 19*22*and that death occurred, on the date stated above, at *1 a.* m.

The CAUSE OF DEATH\* was as follows:

*Valvular disease of heart**Unknown* (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? *W. Alderman* M. D.*7* 1922 Address *1133 Valley in*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*New Cathedral Church**May 9/22*

20 UNDERTAKER

ADDRESS

*F. A. Trause & Son**739 Hughes*

Information should be carefully supplied. All should be stated EXACTLY. Exact statement of OCCUPATION OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



D 62093

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

ST.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 4 mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

MAR 8 - 1922 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, that I attended deceased from

that I last saw alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. W. Scott M. D.

19 (Address) St. Agnes Hospital

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Robert Brooks &amp; Son

Hollins St

Exact statement of OCCUPATION is very important. See instructions on back of certificates.



D 62094

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

113

REGISTERED No.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3223 Foster Ave ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Mazurek

(a) RESIDENCE. No. 3223 Foster Ave ST. 1 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 27-22

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

8

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

—

(c) Name of employer

—

9 BIRTHPLACE (city or town) (State or country)

Balt.

Md

10 NAME OF FATHER Marcel Mazurek

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER Martha Wolucka

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Marcel Mazurek 3223 Foster Ave

15

MAR 8-1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7- 1922

17

I HEREBY CERTIFY, That I attended deceased from Mar 6, 1922, to Mar 7, 1922,

that I last saw him alive on Mar 6, 1922,

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation (Signed) Dr. B. J. Titlow, M. D.

3/8, 1922 Address 315 S. Highland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Stanislaus Bene Mar 8- 1922

20 UNDERTAKER

ADDRESS

St. Stanislaus Bene

D 62095

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62095

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *413 Forrest* ST., *5* WARD)

## 2-FULL NAME

(a) RESIDENCE NO. *413 Forrest* ST., *5* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Male white Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb 9-1922*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER *John Buscemi*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *Mary Colapetro*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAR 8-1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 7 1922*17 I HEREBY CERTIFY that I attended deceased from *Mar 6 1922* to *Mar 7 1922*that I last saw him alive on *Mar 7 1922*and that death occurred, on the date stated above, at *5:00 P. m.*

The CAUSE OF DEATH\* was as follows:

*Primary*  
*Broncho Pneumonia*  
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Luigi Di Stefano* M.D.  
*Mar 8 1922* Address *407 N. Egle St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Holy Redeemery Cem. Mar. 8 1922*

20 UNDERTAKER

ADDRESS

*George J. Ruth. 1735 Harbor Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

# Selma M<sup>rs</sup> Intire ✓

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62096

## CERTIFICATE OF DEATH.

129 D 62096

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1236 Hull.ST.: 2nd WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. 1236 Hull.

(Usual place of abode)

ST.: 2nd WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 44.25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced Married (or) WIFE of Thos. M. Intire

6 DATE OF BIRTH (month, day, and year) Dec. 11, 1872

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
49 2 23

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Rhode Island  
(State or country)10 NAME OF FATHER Albert Tucker11 BIRTHPLACE OF FATHER (city or town) R. I.  
(State or country)12 MAIDEN NAME OF MOTHER Martha Lenoir13 BIRTHPLACE OF MOTHER (city or town) R. I.  
(State or country)

14 Informant Thos. M. Intire  
(Address) 1236 Hull

15 FILED MAR 8 - 1922 ROBERT R. KRAUTER,  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1921, to Mar. 6, 1922, that I last saw her alive on Mar. 6, 1922, and that death occurred, on the date stated above, at 5:30 A m.  
The CAUSE OF DEATH<sup>1</sup> was as follows:

Chronic Interstitial NephritisAbout 2 yrs. mos. ds.  
(duration)CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? No Date of No.

Was there an autopsy?

What test confirmed diagnosis? Urinary(Signed) Wm. Seabury M. D.3/8, 1922 (Address) 635 7th

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Landon ParkMar 8 1922

20 UNDERTAKER

Margaret G. Flynn

ADDRESS

1422 1st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

D 62097

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

135 D 62097

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST.: *6* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Sigmund Ludwig*(a) RESIDENCE. NO. *107 Lakewood Ave.* ST.: *6* WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *10* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? *0* yrs. *0* mos. *0* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Mary A Ludwig*6 DATE OF BIRTH (month, day, and year) *Dec. 23 1851*7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*70* *2* *12*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Blacksmith*(b) General nature of industry, business, or establishment in which employed (or employer) *Himself*

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country)10 NAME OF FATHER *John Ludwig*11 BIRTHPLACE OF FATHER (city or town) *Germany*  
(State or country)12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) *Germany*  
(State or country)

14

Informant *Mary Ludwig*(Address) *107 70 Lakewood Ave.*

15

MAR 8 - 1922

ROBERT R. KRAUTER,

Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 7 1922*17 I HEREBY CERTIFY, That I attended deceased from *March 5*, 1922, to *March 7*, 1922, that I last saw him alive on *March 7*, 1922, and that death occurred, on the date stated above, at *12:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Myocardial insufficiency  
Pyonephritis.*(duration) *2* yrs. *0* mos. *0* ds.CONTRIBUTORY (Secondary) *Hypertrophied Prostate*(duration) *10* yrs. *0* mos. *0* ds.15 Where was disease contracted if not at place of death? *Home.*Did an operation precede death? *No* Date of *No*Was there an autopsy? *No*What test confirmed diagnosis? *P. S. & Laboratory*(Signed) *F. C. Marino* M. D., 19 (Address) *68 St Joseph's Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Baltimore Cem.*DATE OF BURIAL *Mar. 10 1922*20 UNDERTAKER *Philip's Service*ADDRESS *2016 Orleans*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.



D 62098

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62098

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 605 West Ave. ST. 10 WARD)

## 2-FULL NAME

William J. Eichorn

## (a) RESIDENCE

No. 605 West Ave ST. 10 WARD. (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male White

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2130

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant (Address)

Martin Eichorn  
605 West Ave

ROBERT R. KRAUTER, Registrar

MAR 8 - 1922

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Mar. 7 1922

## 17

I HEREBY CERTIFY, That I attended deceased from March 7, 1922, to March 7, 1922 that I last saw him alive on March 7, 1922 and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH\* was as follows:

Laryngeal Diphtheria(duration) yrs. mos. ds. 2

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

UnknownDid an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert H. Webster M. D.19 (Address) 783 Belair Rd.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Redeemer

## 20 UNDERTAKER

Philip's Burial

## DATE OF BURIAL

Mar 8 1922

## ADDRESS

2016 Orleans St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 62099

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62099

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 23 W. Camden St., St. 22 Ward)

Registered No. C. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number and All out No. 18.)

2-FULL NAME Frank Ejmont.

(Residence in Baltimore: No. 23 W. Camden St., St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male.

4-COLOR OR RACE,

White.

5-Single, Single  
Married,  
Widowed,  
or Divorced,  
(Write the word.)

6-DATE OF BIRTH.

Do not know., 1.  
(Month) (Day) (Year)

7-AGE,

70

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Lithuania.

10-NAME OF FATHER,

Do not know.

11-BIRTHPLACE OF FATHER,

(State or Country),

Do not know.

12-MAIDEN NAME OF MOTHER,

Do not know.

13-BIRTHPLACE OF MOTHER,

(State or Country),

Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Bradunos.

(Address) 20 W. Camden St.

15-

MAR 8 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March, 6th, 1922.

(Month)

(Day)

192

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry

find that said deceased came to death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute Alcoholism.

(Duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

March 7, 1922

(Address)

1017 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Stanislovas

March 7th 1922

20-UNDERTAKER,

ADDRESS

James G. Glibiauckas

425 S. Pea St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62100

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 Leadenhall ST. 23 WARD)2-FULL NAME Hilda Bennett(a) RESIDENCE. NO. 1009 Leadenhall ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 0 mos. 0 ds. Now long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fe 4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓6 DATE OF BIRTH (month, day, and year) July 16<sup>th</sup> 19197 AGE Years Months Days If LESS than 1 day, hrs. or min.  
2 7 18

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None(b) General nature of industry, business, or establishment in which employed (or employer) ✓(c) Name of employer ✓9 BIRTHPLACE (city or town) Balto, MD (State or country)10 NAME OF FATHER James Bennett11 BIRTHPLACE OF FATHER (city or town) MD (State or country)12 MAIDEN NAME OF MOTHER Rachael Fisher13 BIRTHPLACE OF MOTHER (city or town) MD (State or country)14 Informant Rachael Bennett (Address) 1009 Leadenhall St.

MAR 8 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 6<sup>th</sup> 192217 I HEREBY CERTIFY, That I attended deceased from Mar 5<sup>th</sup> 1922, to Mar 6<sup>th</sup> 1922, that I last saw her alive on Mar 6<sup>th</sup> 1922, and that death occurred, on the date stated above, at 5<sup>4</sup> m. The CAUSE OF DEATH\* was as follows:Lobar Pneumonia(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓Did an operation precede death? No Date of ✓Was there an autopsy? NoWhat test confirmed diagnosis? General exam.(Signed) D. H. Carroll, M. D.3/7, 1922 (Address) 1400 W. Hill St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn exMarch 9 1922

20 UNDERTAKER

ADDRESS

J. H. Brown & Son108 W. Monte

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62101

## CERTIFICATE OF DEATH.

D 62101

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Frederick Road & Athol Ave.* ST., *28* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. *Frederick Rd. & Athol Ave.* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred *70* yrs. *8* mos. *2* ds. How long in U. S., if of foreign birth? *5* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Bertha Kuiper*6 DATE OF BIRTH (month, day, and year) *June 14 1851*7 AGE Years *70* Months *8* Days *22* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired Builder*

(b) General nature of industry, business, or establishment in which employed (or employer)

*016*

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto.* (State or country) *md.*10 NAME OF FATHER *Francis J. Kuiper*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Dorothea Klug*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)14 Informant *M. Leo. Kuiper* (Address) *Frederick Rd. & Athol Ave.*15 *MAR 8 - 1922* ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 6 1922*

17 I HEREBY CERTIFY, That I attended deceased from

*June 15 1918*, to *March 6 1922*.that I last saw him alive on *March 6 1922*and that death occurred, on the date stated above, at *10:30 P. m.*

The CAUSE OF DEATH\* was as follows:

*Arterio Sclerosis*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Henry Maher* M. D.*37*, 1922 (Address) *7315 Franklin St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*London Park Cemetery*

DATE OF BURIAL

*Mar 9 1922*

20 UNDERTAKER

*Henry Horck Low*

ADDRESS

*1301 E Eager St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.



D 62102

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST.: *8* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. *2215 E. Chase* ST., WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Female**White**Married*

5a If married, widowed, or divorced

HUSBAND of *Harry M. Siegle*

(or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 20, 1888*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*33**7**16*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Insurance 037*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balt.* (State or country)10 NAME OF FATHER *Fredrick Ehlers*11 BIRTHPLACE OF FATHER (city or town) *Balt.* (State or country)12 MAIDEN NAME OF MOTHER *Jarah F. Beasley*13 BIRTHPLACE OF MOTHER (city or town) *Balt.* (State or country)

14

Informant *Mr. Fred. Ehlers* (Address) *2215 E. Chase*

15

MAR 8 - 1922

ROBERT R. KRAUTER, Registrar

Rural Electric Clock

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3 - 6 - 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*3 - 3 - 1922*, to *3 - 6 - 1922*that I last saw her alive on *3 - 6 - 1922*,and that death occurred, on the date stated above, at *8:00 P.* m.

The CAUSE OF DEATH\* was as follows:

*Myocardial Insufficiency*(duration) *Unknown* yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Pneumonia (lobar)**Unknown* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Herman J. Dorf*, M. D., 19 (Address) *St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Baltimore Cemetery**Mar.* 19 *22*

20 UNDERTAKER

ADDRESS

*Henry Hozok Son**1301 E. Eager St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62103

## CERTIFICATE OF DEATH.

179 D 62103

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3203 Stafford St. ST. 20 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME Amelia Dixon

(a) RESIDENCE No. 3203 Stafford St. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William T. Dixon

6 DATE OF BIRTH (month, day, and year) Jan. 17 1869

7 AGE Years 53 Months 1 Days 17 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER Herman Gunther

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Katherine Schreiner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William T. Dixon (Address) 3203 Stafford St.

15 MAR 8 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 6 19 22

17 I HEREBY CERTIFY That I attended deceased from Feb 18 1922 to Mch 6 1922 that I last saw her alive on Mch 5 1922

and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH\* was as follows:

Nephritis

about (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of Mch 5

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. D. Thomas, M. D.

Mch. 6 1922 (Address) 330 N. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park Cem

March 8 19 22

UNDERTAKER

ADDRESS

Joseph B. Cook

1003 N. Baltimore St



D 62105

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## PLACE OF DEATH

CITY OF BALTIMORE (NO. 12 St.arts Lane ST. WARD)

FULL NAME Baby Burton

(Residence in Baltimore: No. 12 St.arts Lane

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female  
4-COLOR OR RACE Col  
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Boy  
6-DATE OF BIRTH, Jan 3, 1912  
(Month) (Day) (Year)

7-AGE, 3 yrs., 4 mos., ds.  
If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work Baby, no  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto

10-NAME OF FATHER, Adolf Burton

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Clara Gropman

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara Gropman

(Address) 12 St.arts Lane

15- MAR 8 - 1922 191 Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 7, 1912  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry, thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lock of Car  
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)  
(Duration) ... yrs. ... mos. ... ds.  
(Signed) J. H. Miller M. D.  
(Coroner)  
3-8-101 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, 19...

Mc Auburn Cemetery

20-UNDERTAKER ADDRESS

Robert E. Williams 1106 Ashland an



D 62106

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

3D 62106

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *St Joseph Hospital* ST.: *9* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs. Amanda Burlingham*(a) RESIDENCE. NO. *Bear Creek, Md.* ST.: *Bear Creek, Balt., Md.* WARD: *Bear Creek, Balt., Md.*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds.

yrs.

mos.

ds.

How long in U. S., if of foreign birth? 44 yrs. mos. ds.

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, Divorced (write the word)

*Married*

5a If married, widowed, or divorced

(or) WIFE of *Charles Burlingham*6 DATE OF BIRTH (month, day, and year) *July 25<sup>th</sup> 1860*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*67**8**—*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*At Home**037*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Ohio*10 NAME OF FATHER *Henry Broombaugh*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ohio*12 MAIDEN NAME OF MOTHER *Louisa Boecker*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ohio*

14

Informant *Charles Burlingham*(Address) *Bear Creek, Maryland*

15

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May, 4* 1922

17

I HEREBY CERTIFY, That I attended deceased from *Feb. 25,* 1922, to *March 4,* 1922, that I last saw her alive on *March 4,* 1922, and that death occurred, on the date stated above, at *9.15 P. m.*

The CAUSE OF DEATH\* was as follows:

*Chronic interstitial nephritis. Coronary atherosclerosis*

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) *hypertension*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *2-27-22*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *J. C. Ponte, Jr.* M. D.19 (Address) *St. Joseph's Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Woodlawn London Park Vault* *3-9-1922*

20 UNDERTAKER

ADDRESS

*William Cook 502 E. North Ave.*

AR 8-1922

Burial Permit Clerk,

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62107

HEALTH DEPARTMENT-CITY OF BALTIMORE

D 62107

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

728 Linwood Ave.

ST

WARD

27

FULL NAME

Mary M. Shaw

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

728 Linwood Ave. Roland Park

St.

yrs.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

f

COLOR OR RACE

White

SINGLE, MARRIED, OR DIVORCED

(Write the word)

Single

DATE OF BIRTH

Aug 27<sup>th</sup>, 1904

AGE

17

yrs.

5

mos.

20

ds.

If LESS than 1 day, hrs. or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

None

000

BIRTHPLACE (State or country)

Pa.

NAME OF FATHER

Homeer Shaw

BIRTHPLACE OF FATHER (State or country)

Pa

MAIDEN NAME OF MOTHER

Emma Backman

BIRTHPLACE OF MOTHER (State or country)

Md.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Tho. Smith

(Address)

728 Linwood Ave.

17

Robert P. Harrison,

DATE OF DEATH

March

7<sup>th</sup>

, 1922

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

Mar 4<sup>th</sup>, 1922, to, Mar 7<sup>th</sup>, 1922,

1922, to, Mar 7<sup>th</sup>, 1922,

1922,

that I saw her alive on

Mar 7<sup>th</sup>, 1922,

1922,

and that death occurred, on the date stated above, at 1<sup>45</sup> p. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia (Influenza)

Contributory (SECONDARY)

Epilepsy

(Duration)

yrs.

mos.

ds

(Signed)

W. D. Clarke

M. D.

Mar 7<sup>th</sup>, 1922

(Address) 1 St. John Rd. - Roland Park

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL OR CREMATION

DATE OF BURIAL

Woodlawn Cemetery

March 9, 1922

20

ADDRESS

William Cook 5026 North Ave.

MAR 8 - 1922

Permit Clerk

REGISTRAR

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62108

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (NO. 221 S. Bouldin ST. WARD 70)

## 2. FULL NAME

(a) RESIDENCE NO. 221 S. Bouldin ST. WARD 70

(Usual place of abode) Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth 12 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced, HUSBAND of Amelia J. Linthicum (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 26, 1842

7 AGE Years 79 Months 5 Days 0 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 030

(b) General nature of industry, business, or establishment in which employed (or employer) Retail

(c) Name of employer Bowdoin &amp;

## 9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Thomas Linthicum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Kate Reinecke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Caseville, Mo.

14 Informant Amelia J. Linthicum (Address) 221 S. Bouldin ST. BALTIMORE, MD.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7, 1922

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1922, to March 7, 1922, that I last saw him alive on March 6, 1922, and that death occurred, on the date stated above, at 2:32 P.M.

The CAUSE OF DEATH\* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adams, J. D. M. D.

19 (Address) 4704 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOCAL

DATE OF BURIAL 3/10 1922

ADDRESS

20 UNDERTAKER William C. 302 E. N. B. Ave

R 8-1922

4704 Eastern Ave.

D 62109 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 62109

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 V. Milton ST., 1 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

James A. Wilson

## (a) RESIDENCE NO.

504 V. Milton

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

69 mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Matilda Wilson

## 6 DATE OF BIRTH (month, day, and year)

Sept 25, 1847

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

74

5

12

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Carroll Co.  
Maryland.

## 10 NAME OF FATHER

Henry Wilson

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Elizabeth Ayres

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

## 14

Informant  
(Address)

Matilda Wilson

504 V. Milton Ave.

AR 8-1922

## 15

Registar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Mar 7 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

June 13, 1920, to March 7, 1922

that I last saw him alive on Feb. 14, 1922

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart  
Disease  
about 2 yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Physical

(Signed) Geo. Heller M. D.

3/7/1922 Address 1937 Gough St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Seaford Delaware

Mar 10 1922

## 20 UNDERTAKER

## ADDRESS

H. Sanders Sons

1700 Fleet St.



D 62110

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62110

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 S. East Ave ST., 76 WARD)

## 2. FULL NAME

Lewis M. Smart

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

813 S. East Ave ST.,

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofAlice Smart

## 6 DATE OF BIRTH (month, day, and year)

June 21, 1849

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.72815

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Scott Inspector

(b) General nature of industry, business, or establishment in which employed (or employer)

OSB

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Maryland

## 10 NAME OF FATHER

James Smart

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Ann Dorney

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

## 14

Informant  
(Address)Alice Smart  
813 S. East Ave

## 15

AR 8-1922

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6, 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1922, to March 6, 1922,that I last saw him alive on March 6, 1922,and that death occurred, on the date stated above, at 9:14 P.M.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis(duration) yrs. 4 mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. B. Atley, M. D.37, 1922 (Address) 2504 St. Paul St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

## DATE OF BURIAL

Mt Carmel Cem. March 9, 1922

## 20 UNDERTAKER

## ADDRESS

H. Sander Sons 1710 Fleet St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62111

## CERTIFICATE OF DEATH.

D 62111

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3732 E. Lombard ST., 76 WARD)

## 2-FULL NAME

Clarence E. Harrison

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

3732 E. Lombard ST.,

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

6 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Royce A. Harrison

## 6 DATE OF BIRTH (month, day, and year)

Oct 16, 1872

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

49

4

18

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Fireman

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

Continental Can Co.

## 9 BIRTHPLACE (city or town) (State or country)

St. Michaels Maryland

## 10 NAME OF FATHER

Charles Harrison

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Sarah Bruff

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

## 14

Informant (Address)

Edward E. Harrison 3732 E. Lombard St.

## 15

Informant (Address)

Robert P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 6 1922

## 17 I HEREBY CERTIFY, That I attended deceased from

Feb 28 22 to Mar 6 22

that I last saw him alive on Mar 6 1922

and that death occurred, on the date stated above, at 7 P. m.

## The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

## CONTRIBUTORY (Secondary)

Influenza

(duration) yrs. mos. 8 ds.

## 18 Where was disease contracted if not at place of death?

dormitory

## Did an operation precede death? NO Date of

## Was there an autopsy? NO

## What test confirmed diagnosis? clinical

(Signed) J. K. Smiley M. D.

571922 (Address) 29385 Baltimore

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt. Carmel Cem.

## DATE OF BURIAL

March 19 22

## 20 UNDERTAKER

H. Sander Sons

## ADDRESS

1710 Plea

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MAR 8-1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10476) 62112

ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William Modzelesky

(a) RESIDENCE. No.

407 So. Bond

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. life mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct. 1 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Edward Modzelesky

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Sophia Binkowski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant

(Address)

15

Filed

A 19

Robert P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 7 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 3<sup>rd</sup>, 1922, to March 7<sup>th</sup>, 1922that I last saw him alive on March 7<sup>th</sup>, 1922

and that death occurred, on the date stated above, at 10:15 P.M.

The CAUSE OF DEATH\* was as follows:

Pneumonia, Broncho- (primary)

(duration) yrs. mos. ds. 10

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death?

No

Date of

Was there an autopsy?

What test confirmed diagnosis?

X Ray

(Signed)

Horace G. Stewart

M. D.

37

19

(Address)

Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary Cemetery

Mar 9 1922

20 UNDERTAKER

ADDRESS

A. Vandev &amp; Sons

170 Fleet St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62113

D 62113

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes Hospital* ST. *70* WARD)

## 2. FULL NAME

(a) RESIDENCE NO. *2617 Lehigh St.* ST. *70* WARD

(Usual place of abode)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred *8* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? *unknown* mos. *0* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *John Fischer*6 DATE OF BIRTH (month, day, and year) *about 65 yrs.* Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant (Address)

## 15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 7* 19 *22*17 I HEREBY CERTIFY That I attended deceased from *Jan. 21*, 19 *22* to *March 7*, 19 *22*, that I last saw her alive on *March 7*, 19 *22*, and that death occurred, on the date stated above, at *4:00 a.m.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Stomach with general metastasis to Abdominal cavity and Liver*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *Cardiac failure* 2 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *W. Caldwell*, M. D.19 (Address) *St. Agnes Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R8-1922



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62114

## CERTIFICATE OF DEATH.

179 D 62114

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4406 Grosland Ave. ST. 28 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Lucinda Catherine McLaughlin

(a) RESIDENCE. NO. 4406 Grosland Ave. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 13, 1851

7 AGE Years 71 Months 1 Days 24 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ma

10 NAME OF FATHER

Geo L. McLaughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER

Elizabeth Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

## PARENTS

14 Informant Mary L. Kuesche (Address) 4406 Grosland Ave

15 Filed Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 1920, to Mar 1922.

that I last saw her alive on Mar 6, 1922.

and that death occurred, on the date stated above, at 11:10 p. m.

The CAUSE OF DEATH\* was as follows:

Mitral Regurgitation

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? NO Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptomatology

(Signed) Henry H. Chance M. D.

2/8 1922 (Address) 3982 Grosland Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Green Mount Cem.

Mch 10 1922

## UNDERTAKER

## ADDRESS

Harry W. Chlen

W. Norton

8-1922

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Chronic interstitial  
nephritis*

D 62115 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62115

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1235 W Cross St., 21 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E. Henthorn(Residence in Baltimore: No. 1235 W Cross St.; yrs.,.....mos.....ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced, Married  
(Write the word.)6-DATE OF BIRTH, Nov 19, 1864  
(Month) (Day) (Year)7-AGE, 57 yrs. 3 mos. 15 ds. If LESS than 1 day, ....hrs. or....min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, Housework  
(b) General nature of industry, business, or establishment in which employed (or employer), at home9-BIRTHPLACE, (State or Country), Balt. Md.10-NAME OF FATHER, Peter Waller11-BIRTHPLACE OF FATHER, (State or Country), Balt City12-MAIDEN NAME OF MOTHER, Sarah E. Lambert13-BIRTHPLACE OF MOTHER, (State or Country), Balt Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James H Henthorn(Address) 1235 W Cross

15-

Robert P. Harrison,

Filed.....192..... Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 6, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said Inquest, find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Angina Pectoris

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY Rupture coronary artery  
(Secondary) rupture(Signed) James H. Henthorn M. D.

(Coroner.)

Mar 7, 1922 (Address) 700 E Ches

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Notllin Cemetery Mar 10, 1922

20-UNDERTAKER, ADDRESS

Harry H. Amacook 4204 Ridgewood Ave

is very important. See instructions on back of certificate.

8-1922

D 62116

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 26 WARD)2-FULL NAME Richard Wister(a) RESIDENCE. NO. Bay View Asylum  
(Usual place of abode)ST. 26 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18517 AGE Years 70 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Meat cutter 013(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER Severe Wister11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Betty Daniels13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant Hospital Records  
(Address) M.T.H.

AR 8-1922

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 192217 I HEREBY CERTIFY, That I attended deceased from Feb. 13, 1922, to March 5, 1922, that I last saw him alive on March 5, 1922, and that death occurred, on the date stated above, at 9.40 p. m.  
The CAUSE OF DEATH\* was as follows:Pulmonary tuberculosis(duration) yrs. 9 mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Unknown  
If not at place of death?Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray(Signed) Francis DeBagliano M. D.3-6-22 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Patrick's Cemetery3/8 1922

20 UNDERTAKER

Mrs. M. FinkADDRESS 1835 W. Pratt St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62117

D 62117

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *7 Wyndhurst Ave.* ST. *27* WARD)2. FULL NAME *William Selden Cooper*(a) RESIDENCE NO. *7 Wyndhurst Ave.* ST. *27* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *8* mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M.*4 COLOR OR RACE *A*5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Fannie Cooper*6 DATE OF BIRTH (month, day, and year) *Feb. 26 1844*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*81**9*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) *A.C.*10 NAME OF FATHER *Am Cooper*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Fa*12 MAIDEN NAME OF MOTHER *Martha Miller*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Fa*

14

Informant  
(Address) *Mr. F. B. Cooper*  
*7 Wyndhurst Ave.*

15

*Robert P. Harrison,*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 7 1922*

17

I HEREBY CERTIFY, That I attended deceased from  
*Oct. 1*, 1920, to *Mar. 7*, 1922,  
that I last saw him alive on *Mar. 7*, 1922,  
and that death occurred, on the date stated above, at *10<sup>30</sup> P. m.*

The CAUSE OF DEATH\* was as follows:

*Arterio Sclerosis*CONTRIBUTORY (duration) *3* yrs. mos. ds.  
*Chronic distended nephritis*  
(Secondary) (duration) *1* yrs. 6 mos. ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physical*  
(Signed) *Wm. S. Hooper*, M. D.*3-8, 1922* (Address) *5600 York Rd.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *Wood Lane -*

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Am Cook**Mar 10 1922*  
*A. S. Mc-*

CAUSE OF DEATH is very important. See instructions on back of certificates.

8-1922

Burial Permit Clerk.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62118

D 62118

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2655 Weslens Ave* ST.: *70* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Lillian Irene Cookerly*(a) RESIDENCE. NO. *2655 Weslens Ave* ST.,

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *18* yrs. *6* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced

~~HUSBAND~~ of

(or) WIFE of

*John M. Cookerly*6 DATE OF BIRTH (month, day, and year) *1878*7 AGE Years *43* Months *11* Days *7* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Home Wife* *037*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Frederick Co., Md.* (State or country)10 NAME OF FATHER *Samy F. Kelly*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Pennsylvania*12 MAIDEN NAME OF MOTHER *Mary M. Burd*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Frederick Co., Md.*14 Informant *John M. Cookerly* (Address) *2655 Weslens Ave*15 *Robert P. Harrison,*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 7* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *Sept 15*, 19 *21*, to *Mar 6*, 19 *22*,that I last saw him alive on *Mar 6*, 19 *22*,and that death occurred, on the date stated above, at *1:30 A.M.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Uterus*(duration) yrs. *7* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Harry Glasman* M. D.Place of death *2655 Weslens Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Greenwood Cemetery* *Mar 9* 19 *22*

20 UNDERTAKER ADDRESS

*Harry H. Witzke* *1531 W. Lombard*

CAUSE OF DEATH is very important. See instructions on back of certificates.

88-1922

D 62119

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

H1 D 62119

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *Mercy Hospital* ST.: *7* WARD)

## 2-FULL NAME

*Ernest Lamb*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. *1609 Millman* ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *3* yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*male*

## 4 COLOR OR RACE

*colored*

## 5 Single, Married, Widowed, or Divorced (write the word)

*single*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*single*

## 6 DATE OF BIRTH (month, day, and year)

*Dec 4, 1892*

## 7 AGE

*29*

Years

Months

*3*

Days

*3*If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Delaware*

## 10 NAME OF FATHER

*James Lamb*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Del.*

## 12 MAIDEN NAME OF MOTHER

*Louise Allen*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Del.*

## 14

Informant (Address)

*Mercy Hospital Records*

## 15

*MAR 9 - 1922*

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*March 7, 1922*

## 17

HEREBY CERTIFY, That I attended deceased from

*Feb 9, 1922, to March 7, 1922.*that I last saw him alive on *March 7, 1922.*and that death occurred, on the date stated above, at *3:45* m.

The CAUSE OF DEATH\* was as follows:

*Posterior dislocation of right hip (due to a fall 2 weeks before admission to hospital which resulted in a sprain)**Infected wound and suppuration of hip joint**Open fracture of hip, Feb 18, 1922*Was there an autopsy? *no*What test confirmed diagnosis? *Findings signs & symptoms*(Signed) *John J. Egan* M. D.19 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Laurel Del.**Mar. 18 1922*

## 20 UNDERTAKER

## ADDRESS

*Chas. N. Johnson 401 N. Charles*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62120

## CERTIFICATE OF DEATH.

146 D 62120

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 227 N Bond St. ST.; 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Sunkett(Residence in Baltimore: No. 227 N Bond St. St.; 10 yrs., 10 mos., 10 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female4-COLOR OR RACE White5-SINGLE, Married  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)6-DATE OF BIRTH, Jan 1

(Month)

(Day)

(Year)

7-AGE, 28yrs. 10 mos. 10 da.

If LESS than 1 day,

...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work House Wife(b) General nature of industry, business, or establishment in which employed (or employer) House Wife9-BIRTHPLACE, Washington, D.C.

(State or Country)

## PARENTS.

10-NAME OF FATHER, William Louis11-BIRTHPLACE OF FATHER (State or Country), Washington12-MAIDEN NAME OF MOTHER Carrie Johnson13-BIRTHPLACE OF MOTHER (State or Country), Richmond Va

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Louis(Address) 227 N. Bond St.

## 15-

ROBERT R. KRAUTER,

Burial Permit Clerk, Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 6, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1, 1922, to March 6, 1922that I saw him alive on March 6, 1922and that death occurred, on the date stated above, at 2 P.m.

The CAUSE OF DEATH\* was as follows:

Perforated ulcer of stomach  
infected uterus following  
instrumental delivery of fetus  
at full term (Duration) 1 yrs. 11 mos. 11 da.

## CONTRIBUTORY (Secondary)

Laceration of perineum(Signed) Richard L. Eustace, M.D.Mar 7, 1922 (Address) 151 E. Baltimore St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 10 mos. 10 da. In the State 1 yrs. 10 mos. 10 da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn CemDATE OF BURIAL, March 7, 192220-UNDERTAKER, Mr. Robert A. ElliottADDRESS 772 Ashland

important. See instructions on back of certificate.

MAR 9 - 1922



D 62121

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 62121

## CERTIFICATE OF DEATH.

11-001

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1411 Jew Pin alley ST.: 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Raymond Hays Jr.

(a) RESIDENCE. NO. 1411 Jew Pin alley ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 2 ds

How long in U. S., if of foreign birth? yrs. mos. ds

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

colored

5 Single, Married, Widowed, or Divorced (write the word)

Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 9, 1921

7 AGE 1 Years Months Days 25 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt. Md. born in Balt City

10 NAME OF FATHER

Raymond Hays Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt. Md.

12 MAIDEN NAME OF MOTHER

Mamie Barnett

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14 Informant (Address)

Benjamin Richard 1411 Jew Pin alley

15 Filed

MAR 9 - 1922 Burial Permit Clerk, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8, 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10<sup>th</sup>, 1922, to March 7, 1922.

that I last saw him alive on March 7, 1922.

and that death occurred, on the date stated above, at 4:30 a. m.

The CAUSE OF DEATH\* was as follows:

Acute Influenzal Bronchitis

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) R. A. Nicholson M. D.

19 (Address) 2230 Cutaw Place

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laural Cemetery

March 10, 1922

20 UNDERTAKER

ADDRESS 1725

Mrs Robert A Elliott

Ashland St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Enter statement on back of certificate. See instructions on back of certificate.

D 62122

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62122

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1228 Short Alley

ST.

WARD)

## REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Anna Murray

(Residence in Baltimore: No. 1228 Short Alley

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE,

col

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word)

widowed

## 6-DATE OF BIRTH,

(Month) (Day) (Year) 1887

## 7-AGE

35 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

House work

## 9-BIRTHPLACE,

(State or Country),

born in Baltimore

## 10-NAME OF FATHER,

unknown

## 11-BIRTHPLACE OF FATHER

(State or Country),

unknown

## 12-MAIDEN NAME OF MOTHER

unknown

## 13-BIRTHPLACE OF MOTHER

(State or Country),

unknown

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Preston Campbell

(Address)

1228 Short Alley

## 15-

MAR 9 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

May 7, 1912  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Chorea &amp; Infectious Hypertension

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. S. [Signature] M. D.  
(Coroner.)

1228 Short Alley, 1912 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. .... mos. .... ds. In the State.... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

## Former or usual residence.....

## 19-PLACE OF BURIAL OR REMOVAL,

Laural Cemetery

## DATE OF BURIAL,

March 10, 1922

## 20-UNDERTAKER

Mrs Robert A Elliot Ashland Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62123

D 62123

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5840 Bellona Ave. ST. 27 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Langan Strother Randolph

(Residence in Baltimore: No. 5840 Bellona Ave St. 2 yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married (Write the word.)

6-DATE OF BIRTH. May 13, 1859 (Month) (Day) (Year)

7-AGE. 62 yrs. 9 mos. 22 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. Mechanical Engineer  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country), Martinsburg, West Va.

10-NAME OF FATHER. James L. Randolph  
11-BIRTHPLACE OF FATHER (State or Country), Georgetown, D. C.  
12-MAIDEN NAME OF MOTHER. Emily Strother  
13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. Randolph

(Address) 5840 Bellona Ave.

MAR 9-1922

ROBERT R. KRAUTER

Filed MAR 9 1922 Burial Permit

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Mch 7, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1921, to Mch 7 1922, that I saw him alive on Mch 7 1922, and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH\* was as follows:

Arterial hemorrhage - L. hemiplegia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 3 yrs. ... mos. ... ds.

(Signed) E. H. Mackay M. D.

5835 York Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

Prospect Hill - Conn. Mar 9, 1922

20-UNDERTAKER STEWART &amp; MOWEN COMPANY

ADDRESS 108 W. NORTH AVE.

important. See instructions on back of certificate.

D 62124 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62124

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Preston Apts

ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Colton

(a) RESIDENCE. NO. Preston Apts.

ST.

WARD. (Resident)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 3 mos. 11 ds. How long in U. S., if of foreign birth? 67 yrs. 3 mos. 11 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of  
Sarah Catherine Harker Colton

6 DATE OF BIRTH (month, day, and year) Nov-28-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
67	3	11		

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer) Law

(c) Name of employer (self)

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland

10 NAME OF FATHER William Colton

11 BIRTHPLACE OF FATHER (city or town) Cornwall  
(State or country) England.

12 MAIDEN NAME OF MOTHER Emma Frumbelfeld

13 BIRTHPLACE OF MOTHER (city or town) Wilkes Barre  
(State or country) Pennsylvania14 Informant Mrs. Sarah C. H. Colton, (wife)  
(Address) Preston Apts., City.15 MAR 9-1922 ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8 1922

17 I HEREBY CERTIFY, That I attended deceased from

Oct 1920, 19, to Mar 8, 1922

that I last saw him alive on Mar 7, 1922.

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis.  
Chronic myocarditis.

(duration) 2 yrs. 6 mos. ds.  
CONTRIBUTORY Acute Cardiac Dilatation  
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Elmer B. Freeman, M. D.

, 19 (Address) 412 Calverton St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

DRUID RIDGE CEMETERY

MAR-10-22

20 STEWART & MOWEN COMPANY  
(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.



D 62125

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62125

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Rome 209 Calvert Bldg. Balto. Md.* ST. *4* WARD)

## REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Samuel M. Harder*(Residence in Baltimore: No. *Catonsoile md*

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

## 6-DATE OF BIRTH,

*Sept 25, 1863*  
(Month) (Day) (Year)

## 7-AGE,

*58 yrs. 5 mos. 1 ds.*

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*Superintendent American Ice Co.*

## 9-BIRTHPLACE, (State or Country),

*Balto md*

## 10-NAME OF FATHER,

*Mr Harder*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Balto md*

## 12-MAIDEN NAME OF MOTHER

*Mary Moody*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Balto*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

MAR 9 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*March 8, 1922*  
(Month) (Day) (Year)

## 17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy, or inquiry.)thereon and from the evidence obtained by said *inquest*, andfind that said deceased came to *his* death *from* (Cause of death)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Coronary disease of the heart*(Duration) *about 1 hour*

## CONTRIBUTORY (Secondary)

*Don't know*(Signed) *W. J. G. ...* M. D.

(Coroner)

3-9-22 (Address) *117 W. Saratoga St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Green Mount Cem.**March 10, 1922*

## 20-UNDERTAKER

## ADDRESS

*STEWART & MOWEN COMPANY**108 W North Ave*

(WILLIAM F. WOODEN, Successor)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62126

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2613 E. Fayette ST.; 6 WARD)

## 2-FULL NAME

(a) RESIDENCE. NO. 2613 E. Fayette ST.; 6 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 12/21

7 AGE Years 6 Months 25 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) ORO

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

10 NAME OF FATHER Allen Moore

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Victoria Sak 3-8, 1922

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country)

14 Informant Frank J. Sak (Address) 2613 E. Fayette

15 Filed MAR 9 - 1922 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-8 1922

17 I HEREBY CERTIFY, That I attended deceased from 3-6-22, to 3-8-22

that I last saw him live on 3-7-22

and that death occurred, on the date stated above, at 8 A. M.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Smear

(Signed) F. Fred Meyer, M. D.

Address 700 N. Pratt St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL March 10 1922

20 UNDERTAKER Jos. J. Herr 156 B. Longmeade

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62127

D 62127

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No.

ST.: *26* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

## (a) RESIDENCE. No.

(Usual place of abode)

ST.: *26* WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *1* yrs. *2* mos. *16* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *—*6 DATE OF BIRTH (month, day, and year) *Mar. 21 1920*7 AGE Years *1* Months *2* Days *16* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*(b) General nature of industry, business, or establishment in which employed (or employer) *—*(c) Name of employer *—*9 BIRTHPLACE (city or town) (State or country) *Baltimore Md*10 NAME OF FATHER *George Wyatt*11 BIRTHPLACE OF FATHER (city or town) (State or country) *W Va*12 MAIDEN NAME OF MOTHER *Rosale Quigley*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore Md*

## PARENTS

14 Informant (Address) *George Wyatt 719 1/2 East Ave*

## 15

Filed *19* MAR 9-1922 ROBERT R. KRAUTER, Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 9 1922*17 I HEREBY CERTIFY, That I attended deceased from *3-7*, 1922, to *3-8*, 1922that I last saw him alive on *3-8*, 1922and that death occurred, on the date stated above, at *12:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Bronch. Pneumonia*(duration) yrs. mos. *9* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *—*Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *W. L. Long*

(Signed)

M. D.

*3/9* 1922 (Address) *2701 Eastern*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Oak Lawn Cemetery**Mar 11 1922*

20 UNDERTAKER

ADDRESS *1442**Robt T Turner Inc N Broadway*



D 62128

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

819 N. Fremont ST.

WARD)

## 2-FULL NAME

Louisa E. Bollman

(a) RESIDENCE. No.

819 N. Fremont ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

82 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced

HUSBAND of (or) WIFE

J. Moellinger Bollman

6 DATE OF BIRTH (month, day, and year)

Mar 8 1922

7 AGE

82

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Ralph Brand

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Margaret McEneaney

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant (Address)

Mrs Scott 801 N. Fremont St

15

File

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8 1922

17 I HEREBY CERTIFY, That I attended deceased from

Feb 6 1922 to Mar 8 1922.

that I last saw him alive on Mar 8 1922.

and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH\* was as follows:

Senile dementia from probable cerebral hemorrhage (duration) 7 yrs. mos. ds.

CONTRIBUTORY Cardiac failure (Secondary) (duration) about 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. E. Knipp M. D.

3/8, 1922 Address) 1002 W. Lantvale

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore City 3/9/22

20 UNDERTAKER

J. G. Wether 723 W. Myrtle

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

MAR 9 - 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62129

## CERTIFICATE OF DEATH.

62129

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 N Stricker ST., 16 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Delores Frances Meredith

## (a) RESIDENCE NO.

912 N Stricker

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Jan. 9 1862

## 7 AGE

Years

Months

Days

If LESS than 1 day, 1 hrs. or 40 min.

60139

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

King and Queen county Virginia

## 10 NAME OF FATHER

Mr. Carey Meredith

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

King and Queen Co Va

## 12 MAIDEN NAME OF MOTHER

Frances Ann Roane

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

King and Queen Co Va

## 14

Informant (Address)

Missella Thompson 912 N Stricker

## 15

Filed

MAR 9 1922ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 8 1922

## 17

HEREBY CERTIFY, That I attended deceased from Jan 28, 1921, to March 8, 1922, that I last saw her alive on March 6, 1922, and that death occurred, on the date stated above, at 1.40 a.m.

## The CAUSE OF DEATH\* was as follows:

Locomotor Ataxia(duration) 3 yrs. — mos. — ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Vernon H. Goudon, M. D.(Address) 750 St. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

West Point Va

## DATE OF BURIAL

Mar 9 1922

## 20 UNDERTAKER

Wm J. McKelvey

## ADDRESS

North St

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Dr Vernon Condon*  
*for of no cure + Polton*  
*As far as phy. could*  
*trace back not lactic*  
*in origin*





**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assoc.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name organ; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Child brought in hospital  
with empyema. Could  
not determine whether  
type of pneumonia was  
bronchial or lobar.*

D 62131

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62131

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1502 Hughes Place ST. 19 WARD

## 2-FULL NAME

Willie A Poe

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 1502 Hughes Place  
(Usual place of abode)

ST. 19 WARD.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds.

How long in U. S., if of foreign birth? 2 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos F Poe

6 DATE OF BIRTH (month, day, and year) Jun 7. 1968

7 AGE Years 54 Months 2 Days 1 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lynchburg Va

10 NAME OF FATHER Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Thos F Poe  
(Address) 1302 Hughes

15 MAR 9 - 1922 ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/8/22 19

17 I HEREBY CERTIFY, That I attended deceased from

Mar 31, 1922, to 3/8/22, 19

that I last saw him alive on 3/8/22, 19

and that death occurred, on the date stated above, at 12:15 p.m.

The CAUSE OF DEATH\* was as follows:

Respiratory Failure

(duration) yrs. mos. ds. 5

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 6

18 Where was disease contracted if not at place of death? 1342 McHenry

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. W. Smith M. D.

19, 1922 (Address) 1502 Hughes

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Western

Mar 9 1922

20 UNDERTAKER

ADDRESS

John F. Fields 1200 W. Lombard

CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec. 6-2-12 H. D. Co. - 1000 Bks.  
D 62132

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62132

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1432 McCulloh ST. 14 WARD)

## 2-FULL NAME

(a) RESIDENCE. No. 1432 McCulloh ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1, 1827

7 AGE 94 Years 7 Months 6 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steam Street

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Hardyway Co. Va.

10 NAME OF FATHER Arthur Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hardyway Co. Va.

12 MAIDEN NAME OF MOTHER Polly Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hardyway Co. Va.

14

Informant (Address) Mary F. 1432 McCulloh St.

15

Filed

MAR 9 - 1922

ROBERT R. KRAUTER  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1922

17 I HEREBY CERTIFY, That I attended deceased from March 5 1922, to March 7 1922, that I last saw her alive on March 7 1922, and that death occurred, on the date stated above, at 1:05 P. m.  
The CAUSE OF DEATH\* was as follows:

Influenza

CONTRIBUTORY (Secondary) Age -

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm H Wright M. D.  
(Address) 1209 Presbiterian St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62133

## CERTIFICATE OF DEATH.

H4 D 62133

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1127 Myrtle Ave ST. 17 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Elias Talbot

## (a) RESIDENCE. NO.

1127 Myrtle Ave ST.

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Col

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Lucy Talbot

## 6 DATE OF BIRTH (month, day, and year)

1861

## 7 AGE

61

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Painter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Maryland

## 10 NAME OF FATHER

Henry Talbot

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

## 12 MAIDEN NAME OF MOTHER

Lizzie Ann Rice

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

## 14

Informant  
(Address)Lucy Talbot  
1127 Myrtle Ave

## 15

Filed

MAR 9 1922

ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Mar 7 22

## 17 I HEREBY CERTIFY, That I attended deceased from

Feb 24 1922 to Mar 7 1922

that I last saw him live on Mar 7 1922

and that death occurred, on the date stated above, at 10:30 P. M.

## The CAUSE OF DEATH\* was as follows:

Carcinoma of Stomach  
(inoperable)CONTRIBUTORY  
(Secondary)

(duration) yrs. 6 mos. ds.

(duration) yrs. 14 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

History &amp; Physical Findings

(Signed)

James Brown M. D.

3/8 1922 Address

1837 Penna Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Lutheral Bldg Co. Md

3/10 1922

## 20 UNDERTAKER

## ADDRESS

Lutheral Bldg Co.

W. Biddle



D 62134

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62134

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1119 Kirk

ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

James H. Lee

## (a) RESIDENCE. No.

1119 Kirk St

ST.: 11 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE about 60 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Waiter in 070

(b) General nature of industry, business, or establishment in which employed (or employer)

Boarding house

(c) Name of employer

M. E. Taylor

## 9 BIRTHPLACE (city or town) (State or country)

Frederick, Md.

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

## 14

Informant (Address)

Blanche Anderson 1119 Kirk St

## 15

Filed

MAR 9 - 1922

ROBERT K. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7, 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1922, to Feb. 7, 1922, that I last saw him alive on Feb. 7, 1922, and that death occurred, on the date stated above, at 3:20 P. M. The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia

## CONTRIBUTORY (Secondary)

Influenza (duration) few days about 20 days

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Wm. M. Rinebaker, M. D. 3/8/22 (Address) 1209 Madison av

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Auburn

## DATE OF BURIAL

3/9 1922

## 20 UNDERTAKER

Samuel Hershey

## ADDRESS

578 W. Biddle

CAUSE OF DEATH is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62135

## CERTIFICATE OF DEATH.

D 62135

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2117 Smallwood ST. 15 WARD)

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward W. Burke(a) RESIDENCE. NO. 2117 Smallwood ST.,

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child6 DATE OF BIRTH (month, day, and year) Mar 15, 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1123

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Ivan G. Burke

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md. Baltimore

12 MAIDEN NAME OF MOTHER

Francine Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md. Baltimore

14

Informant (Address)

Ivan G. Burke 2117 Smallwood St.

15

MAR 9 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit 1000

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct. 3, 1921, to March 8, 1922,that I last saw him alive on March 7, 1922,and that death occurred, on the date stated above, at 2:45 A.M.

The CAUSE OF DEATH\* was as follows:

Infantile Cerebral Paralysis  
(duration) yrs. 11 mos. 23 ds.

CONTRIBUTORY (Secondary)

Convulsions(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. K. Skelling, M. D.3-9, 1922 (Address) 4107 Liberty High Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Pk Cemetery, Mar 10, 1922

20 UNDERTAKER

ADDRESS

Charles W. Conklin 9246 Eager

CAUSE OF DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Cerebral hemorrhage.*  
*Instrumental delivery.*  
*Injury at birth.*

D 62136

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62136

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2045 Clifton Ave.* ST. *8* WARD)

## 2-FULL NAME

(a) RESIDENCE No. *2045 Clifton Ave.* ST. *8* WARD(Usual place of abode)  
Length of residence in city or town where death occurred *65* yrs. *8* mos. *3* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *July 8, 1856*7 AGE Years *65* Months *8* Days *3* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired Tailor*(b) General nature of industry, business, or establishment in which employed (or employer) *Clothing Mfr.*(c) Name of employer *none*9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant *Geo. H. Schmidt*  
(Address) *2045 Clifton Ave.*

15

MAR 9 - 1922

ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 8* 19*22*

17 I HEREBY CERTIFY, That I attended deceased from

*Feb. 15 - 1922* to *March 8, 1922*that I last saw him alive on *March 8, 1922*and that death occurred, on the date stated above, at *6:30* A. M.The CAUSE OF DEATH<sup>2</sup> was as follows:*Cardiac dilatation and  
Chronic Nephritis*(duration) *do not know* yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Examination*(Signed) *Benj. S. Hayden*, M.D.5/9, 1922 (Address) *1216 N. Carroll St.*<sup>2</sup>State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL*Baltimore Cemetery*

20 UNDERTAKER

*John Herwig & Co.*

DATE OF BURIAL

*Mar 11* 19*22*

ADDRESS

*2008 Calver*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.



62137

## HEALTH DEPARTMENT—CITY OF BALTIMORE 62137

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 S: 3rd St

ST. 76 WARD

2. FULL NAME Kateherine Schluderberg

(a) RESIDENCE NO. 413 S: 3rd St

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of Conrad Schluderberg (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 19 th 1848

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 73 7 16

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Wm Engel

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Mary Sauers

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Conrad Schluderberg (Address) 413 S: 3rd St

15 MAR 9 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 27 1922 to Mar 7, 1922, that I last saw him alive on Mar 7, 1922,

and that death occurred, on the date stated above, at 11.30 p. m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

Hysteria (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No, Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Analysis

(Signed) Dr. B. Britton, M. D.

19 (Address) 1711 E. Baco. St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Oak Lawn Cemetery

20 UNDERTAKER

John Herwig &amp; Co

DATE OF BURIAL

Mar 11, 1922

ADDRESS 2008 E. Baco. St.

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62138

## CERTIFICATE OF DEATH.

REGISTERED NO. C

D 62138

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1206 E. Hoffman St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1206 E Hoffman St.; Life yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)

6-DATE OF BIRTH, Oct 5, 1875 (Month) (Day) (Year)

7-AGE, 46 yrs. 5 mos. 2 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Secy. U. S. C. A. (b) General nature of industry, business, or establishment in which employed (or employer), O. R. C.

9-BIRTHPLACE, (State or Country), Balto. Md.

10-NAME OF FATHER, John Neumann

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Margaret Hebertmann

13-BIRTHPLACE OF MOTHER, (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Ernest Neumann

(Address), 1206 E. Hoffman St.

15-

Filed MAR 9 - 1922 ROBERT K. KRAUTER Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 7, 1922 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Feb 26 1922, to March 7 1922, that I saw her alive on March 7 1922, and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH\* was as follows:

Cerebral pneumonia complicating  
lobar pneumonia (Duration) 7 yrs. 5 mos. 2 ds.

CONTRIBUTORY (Secondary) Influenza (Duration) 12 yrs. 12 mos. 12 ds.

(Signed) Mary M. D. M. D. Mch 8, 1922 (Address) 1203 W. Fayette St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAVELERS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Ave

DATE OF BURIAL, Mar 10, 1922

20-UNDERTAKER, John Herwig Co

ADDRESS, 2008 Orleans

Important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D. 62139

CITY OF BALTIMORE: (No. 1606 N. Appellton ST., 15 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Blum

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE Years 69 Months 4 Days — If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Chester Yankelevitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Blumina

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14

Informant (Address)

15

Filed

MAR 9 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/9 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1921, to Mar 8, 1922, that I last saw her alive on Mar 8, 1922, and that death occurred, on the date stated above, at 2:09 p.m.

The CAUSE OF DEATH\* was as follows:

Endocarditis -

CONTRIBUTORY (Secondary) (duration) yrs. 6 mos. ds. Nephritis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Koush Tests

(Signed) Shirok M. D.

309, 1929 (Address)

2202 W. North

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Jack Leurs 1439 E. Balto

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62140

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 Frederick Ave. ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1827 Frederick Ave. St. 1 yrs. 1 mos. 24 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE W. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH Jan 9, 1921 (Month) (Day) (Year)

7-AGE 1 yrs. 1 mos. 24 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE (State or Country), Balto. Md.

10-NAME OF FATHER Thomas W. McEachen

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Mary L. Squire

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas W. McEachen

(Address) 1827 Frederick Ave.

15-MAR 9-1922

Filed 191

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. 7, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 7, 1922, to Mar. 7, 1922, that I saw her alive on Mar. 7, 1922, and that death occurred, on the date stated above, at 8 p. m. The CAUSE OF DEATH\* was as follows: Broncho Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) yrs. mos. ds.

(Signed) J. H. Dickson M. D.

Mar. 8, 1922. (Address) 14 N. Monument St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. to the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park

20-UNDERTAKER, Geo. L. Schwalbe

21-ADDRESS, 201 Buck Ave.



*No infection prior*

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

*lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

<i>Abortion,</i>	<i>Cellulitis,</i>	<i>Childbirth,</i>	<i>Convulsions,</i>
<i>Hæmorrhage,</i>	<i>Gastritis,</i>	<i>Erysipelas,</i>	<i>Meningitis,</i>
<i>Gangrene,</i>	<i>Miscarriage,</i>	<i>Necrosis,</i>	<i>Peritonitis,</i>
<i>Phlebitis,</i>	<i>Pyæmia,</i>	<i>Septicæmia,</i>	<i>Tetanus.</i>

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (if induced), whether death is directly or indirectly due to the same.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62141

D 62141

## W. CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1422 Laurel* ST. *16* WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Ella Carey*(Residence in Baltimore: No. *1422 Laurel* St.; yrs., mos., ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *H* 4-COLOR OR RACE. *H* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single* (Write the word.)6-DATE OF BIRTH. *March 10, 1874* (Month) (Day) (Year)7-AGE. *48* yrs., mos., ds. If LESS than 1 day, .... hrs. or .... min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work. *never worked* (b) General nature of industry, business, or establishment in which employed (or employer). *000*9-BIRTHPLACE. (State or Country). *Ind*10-NAME OF FATHER. *Thomas K Carey*11-BIRTHPLACE OF FATHER (State or Country). *Ireland*12-MAIDEN NAME OF MOTHER. *Riley*13-BIRTHPLACE OF MOTHER (State or Country). *Spain*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). *Thos E Carey*(Address). *905 Appleton St*15-*MAR 9 - 1922* Filed *J. E. McPherson* Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *March 9, 1922* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *March 6, 1922* to *March 9, 1922* that I saw him alive on *March 9, 1922* and that death occurred, on the date stated above, at *5 a.m.*The CAUSE OF DEATH\* was as follows: *Broncho Pneumonia*

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) (Duration) .... yrs. .... mos. .... ds.

(Signed) *Edmund A. Morgan* M. D. *March 9, 1922* (Address). *1327 Hurler*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

*New Cathedral* *March 11, 1922*

20-UNDERTAKER ADDRESS

*Chas. E. French* *822 Madison Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62142

62142

## CERTIFICATE OF DEATH.

100-001

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

19 St. Ostend

ST.

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Florence Lambert

## (a) RESIDENCE NO.

19 St. Ostend

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female White

## 4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 5-1866

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

55

6

2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Auto Dept 086

(b) General nature of industry, business, or establishment in which employed (or employer)

Volants

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

## 10 NAME OF FATHER

Sam J. Lambert

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

## 12 MAIDEN NAME OF MOTHER

Catherine J. Lambert

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

## 14

Informant (Address)

Mr Harry C. Shaffer 374 Albemarle Ave

## 15

Filed

MAR 9 - 1922

J. W. K. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar. 7, 1922, to Mar. 7, 1922, that I last saw him alive on Mar. 7, 1922, and that death occurred, on the date stated above, at 2:50 P.M.

The CAUSE OF DEATH\* was as follows:

no sign of J. B.

Bronchopneumonia - alt

(duration) yrs. - mos. 14 ds.

CONTRIBUTORY (Secondary)

Bronchitis

(duration) alt. 4 mos. - ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt. F. Scheidt, M. D.

19 (Address) 1318 P. Charles St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mount Olivet Cemetery

DATE OF BURIAL

Mar 10, 1922

20 UNDERTAKER

John F. Denny

ADDRESS

715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 62143

HEALTH DEPARTMENT—CITY OF BALTIMORE

62143

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3233 Elliott

2-FULL NAME

Sarah Neal

(a) RESIDENCE. No. 3233 Elliott

(Usual place of abode)

Length of residence in city or town where death occurred

Life

mos.

ST. 76

WARD

ST.

WARD.

(If nonresident give city or town and State)

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 9 1922 to March 8 1922. that I last saw her alive on March 7 1922. and that death occurred, on the date stated above, at 9:55 A. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma Rectum

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Date of

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis? Yes - rectum

(Signed)

100 S. Patterson Park Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Bachmans

Mar 12 1922

20 UNDERTAKER

Jirkler & Jirkler

ADDRESS 1739

Eager

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

(or) WIFE of

David Neal

6 DATE OF BIRTH (month, day, and year)

Jan. 24-1862

7 AGE

Years

Months

Days

If LESS than 1 day, hrs.

or min.

60

1

12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Balto., Md.

(State or country)

10 NAME OF FATHER

Melchior Sachs.

11 BIRTHPLACE OF FATHER (city or town)

Balto., Co. Md.

(State or country)

12 MAIDEN NAME OF MOTHER

Madgelina Boll

13 BIRTHPLACE OF MOTHER (city or town)

Germany

(State or country)

14 Informant

(Address)

David Neal

3233 Elliott St.

15 Filed

MAR 9 1922

Registrar

See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62144

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 322 Smadara St., 1 WARD)

2-FULL NAME

Stephen Balidka

(a) RESIDENCE NO. 322 Smadara St., 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 5 mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct. 1921

7 AGE

Years

Months

Days

If LESS than 1 day, 7 hrs. or 2 min.

5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt. Md

10 NAME OF FATHER

Carl Balidka

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Minch

12 MAIDEN NAME OF MOTHER

Mrs. Misch

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Indiana

14

Informant (Address)

Stephen Balidka 322 Smadara St.

15

File

MAR 9-1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7 1922

17 I HEREBY CERTIFY, That I attended deceased from

Oct 8 1921, to Mar 7 1922.

that I last saw him alive on Mar 6 1922.

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH\* was as follows:

Salmon Poisoning

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Daniel J. Fisher M. D.

19 (Address) 332 S Path. Pl. Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

3-9-1922

J. A. Moran

E. Baltrik

D 62145

HEALTH DEPARTMENT—CITY OF BALTIMORE

62145

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1518 E. Federal St.  
CITY OF BALTIMORE: (No. 1518 E. Federal ST., 8 WARD)

2-FULL NAME Mrs. Mary Ellen Redmond

(a) RESIDENCE NO. 1518 East Federal ST., 8 WARD  
(Usual place of abode)(If non-resident give city or town and State)  
Length of residence in city or town where death occurred 64 yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles M. Redmond

6 DATE OF BIRTH (month, day, and year) Mar. 15 1857

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 64 11 22

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.  
(State or country)

10 NAME OF FATHER Patrick Donohue

11 BIRTHPLACE OF FATHER (city or town) Ireland  
(State or country)

12 MAIDEN NAME OF MOTHER Mary Carroll

13 BIRTHPLACE OF MOTHER (city or town) Md.  
(State or country)14 Informant Charles M. Redmond, husband  
(Address) 1518 E. Federal St.

15 Registrar G. Y. MAR 9 - 1922

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1922, to Mar. 7, 1922, that I last saw her alive on Mar. 7, 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows: Chronic Interstitial Nephritis

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 2 yrs. mos. ds.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted Place of death  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Clinical test

(Signed) C. M. Redmond, M. D.

(Address) 1540 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral Cemetery, Mar 10 1922

20 UNDERTAKER

George J. Ruth 1735 Harford Ave.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62146

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Esplanade apt 13* ST. *13* WARD)

## 2-FULL NAME

(a) RESIDENCE NO. *Esplanade apt*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced. *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Ledor Rothschild*6 DATE OF BIRTH (month, day, and year) *Dec 16/1868*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*53**2**10*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country)10 NAME OF FATHER *Samuel Kalin*11 BIRTHPLACE OF FATHER (city or town) *Germany*  
(State or country)12 MAIDEN NAME OF MOTHER *Famir Steiner*13 BIRTHPLACE OF MOTHER (city or town) *Germany*  
(State or country)

14

Informant (Address) *Mr I Rothschild Esplanade*Filed *MAR 9 1922*Registrar *[Signature]*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 8 1922*17 I HEREBY CERTIFY, That I attended deceased from January 10, 1922, to March 8, 1922, that I last saw him alive on March 8, 1922, and that death occurred, on the date stated above, at 7<sup>th</sup> A.M.

The CAUSE OF DEATH\* was as follows:

*Generalized adenomatosis Metastases to brain*

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of *Nov. 1921*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Charles Rustian*

M. D.

19

(Address) *1417 Eutaw Place*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Beth Hellen**Mar 10 1922*

20 UNDERTAKER

ADDRESS

*Harold Bonheim 118 W 4th St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62147

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *St. Joseph's Hospital* ST.: *9* WARD)

## 2-FULL NAME

(a) RESIDENCE. NO. *1209 Fern St. N. W. Wash. D. C.*

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED MD. *161-002*  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Black* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Mar 5-1922*  
7 AGE Years Months Days If LESS than 1 day, hrs. or min. *3 days*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore, Md.*10 NAME OF FATHER *Shannon L. Postner*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore, Md.*12 MAIDEN NAME OF MOTHER *Elizabeth M. Carey*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore, Md.*14 Informant (Address) *Shannon L. Postner 1209 Fern St. N. W. Washington, D. C.*15 Filed *MAR 5-1922* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/8/1922*17 I HEREBY CERTIFY, That I attended deceased from *3/5/1922* to *3/8/1922*, that I last saw him alive on *3/8/1922*, and that death occurred, on the date stated above, at *7:15 P. M.*

The CAUSE OF DEATH\* was as follows:

*Pulmonary Edema*CONTRIBUTORY (Secondary) *Central Hemorrhage* (duration) yrs. mos. *1/2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *T.S. + Symp.*  
(Signed) *Wm. Fowler*, M. D.  
, 19 (Address) *5 E. Preston St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Levin Ridge Cemetery* *3/10-1922*

20 UNDERTAKER ADDRESS

*Chas. J. Evans, Inc.* *118 N. Mt. Royal*

CAUSE OF DEATH is very important. See instructions on back of certificates.



**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Child born at  
St. Joseph's Hopt.  
Transverse presentation  
probable cause of  
hemorrhage.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62148

## CERTIFICATE OF DEATH.

D 62148

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621. Aliceanna

ST.: 2 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madyslaw Majka

(a) RESIDENCE. NO. 1621 Aliceanna

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 2-1921

7 AGE

Years

Month

Days

If LESS than

1 day, hrs.

or min.

8

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

" "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

John Majka

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Eva Szary

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

John Majka 1621 Aliceanna

15

MAR 9-1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 8 1922

17 I HEREBY CERTIFY, That I attended deceased from

Mar 3 1922, to Mar 8 1922

that I last saw him alive on Mar 8 1922

and that death occurred, on the date stated above, at 4:45 p.m.

The CAUSE OF DEATH\* was as follows:

Acute Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

Coronary Polyposis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William H. Ryerson, M. D.

3/9/22 (Address) 801 E. Hampden

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary

Mar 9 1922

20 UNDERTAKER

ADDRESS

William Siefert 618 East

D 62149

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

Registered No. C

D 62149

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3200 E Lombard St. Ward)

## 2-FULL NAME

(Residence in Baltimore: No. 3200 E Lombard St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male	4-COLOR OR RACE, White	5-Single, Married, Widowed, or Divorced, (Write the word.) Single
6-DATE OF BIRTH, March 5 1922 (Month) (Day) (Year)		
7-AGE, yrs. mos. ds. 3 ds.		If LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE, (State or Country), Baltimore		
PARENTS:	10-NAME OF FATHER, Richard Habicht.	
	11-BIRTHPLACE OF FATHER, (State or Country), Baltimore.	
	12-MAIDEN NAME OF MOTHER, Irene Jones.	
	13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore.	

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Habicht.  
(Address) 3200 E. Lombard St.

MAR 9-1922

ROBERT R. KRAUTER,  
Burial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

(Month) (Day) (Year)

## 17-I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) find that said deceased died on the day stated above.

The CAUSE OF DEATH\* was as follows:  
Asphyxial DeathG. B. Gladstone, M.D.  
(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.  
(Signed) J. E. Brady, M.D.  
(Coroner.)

(Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Grundy Cem.

March 9 1922

## 20-UNDERTAKER,

## ADDRESS

Lilly and Fitch

403 S. W. 1st St.

D 62150

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62150

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., 8 WARD)REGISTERED NO.  
(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)2. FULL NAME Frances Langhert(a) RESIDENCE NO. 1116 N. Central Ave. ST., WARD  
(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred life yrs. mos. ds. Now long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed,  
or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of Lewis M. Langhert  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) July 8, 18917 AGE Years Months Days If LESS than  
30 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work housewife 03.7(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country)10 NAME OF FATHER William Meyers11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country)12 MAIDEN NAME OF MOTHER Amelia Miller13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country)14 Informant Lewis Langhert  
(Address) 1116 N. Central Ave.15 MAR 9 - 1922 ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 192217 I HEREBY CERTIFY, That I attended deceased from  
Feb 27, 1922, to March 7, 1922,  
that I last saw her alive on March 7, 1922,  
and that death occurred, on the date stated above, at 3:00 P.m.

The CAUSE OF DEATH\* was as follows:

Acute Appendicitis (Ruptured) with  
general Peritonitis(duration) yrs. mos. 2 ds.CONTRIBUTORY Cardiac Insufficiency  
(Secondary) (duration) yrs. mos. 2 ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? Yes Date of Feb 28, 1922Was there an autopsy? NoWhat test confirmed diagnosis? Clinical Symptoms & Operation(Signed) Lewis C. Widely, M. D.19 (Address) Maryland General Hospital\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Landon Park Cem. March 10, 1922

20 UNDERTAKER

ADDRESS

Lilly and Ziehl403 S. StreetCAUSE OF DEATH in plain terms, so that it may be properly  
TION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>female</i>	4-COLOR OR RACE, <i>brn</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
6-DATE OF BIRTH, <i>March 3, 1921</i> (Month) (Day) (Year)		
7-AGE, <i>1</i> yrs. <i>5</i> mos. <i>5</i> ds.		If LESS than 1 day, ....hrs. or....min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		
9-BIRTHPLACE, (State or Country), <i>Maryland</i>		
PARENTS.	10-NAME OF FATHER, <i>illegitimate child</i>	
	11-BIRTHPLACE OF FATHER (State or Country),	
	12-MAIDEN NAME OF MOTHER <i>Urs Whalin</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Maryland</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-  
Filed *MAR 9-1922* *ROBERT R. KRAUTER,*  
191.....  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *March 8, 1922*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from  
*October 22, 1912*, to *March 22, 1922*,  
that I saw h *er* alive on *March 5, 1922*,  
and that death occurred, on the date stated above, at *8 A.* m.  
The CAUSE OF DEATH\* was as follows:*Congenital Leses*  
(Duration) *1* yrs. .... mos. .... ds.CONTRIBUTORY.....  
(Secondary) (Duration)..... yrs. .... mos. .... ds.(Signed) *Frank J. Quirk* M. D.  
*Mar 8, 1922* (Address) *3095 E. Monument St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *HOPKINS HOSPITAL* DATE OF BURIAL, *1922*

20-UNDERTAKER ADDRESS

*MAR 9-1922*

(over)

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62152

## D 62152 CERTIFICATE OF DEATH.

1. PLACE OF DEATH

University Hospital

CITY OF BALTIMORE: (No.

Lombard &amp; Greene ST.,

WARD)

2. FULL NAME

Baby Jenkins

(a) RESIDENCE NO.

Solley Md

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb 8 1922

7 AGE

Years

Months

Days

If LESS than 1 day, 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

David L. Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pennsylvania

12 MAIDEN NAME OF MOTHER

Mildred Fessler

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pennsylvania

14

Informant (Address)

Mother Solley Md

15

MAR 9 - 1922

ROBERT R. KRAUTER, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 8 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 8 1922, to Feb 8 1922, that I last saw him alive on Feb 8 1922, and that death occurred, on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH\* was as follows:

Prematurity (32 wks fetus)

CONTRIBUTORY (Secondary)

placenta (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

MAR 9 - 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62153

## CERTIFICATE OF DEATH.

57 D 62153  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1003 Harlem Ave ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine P. Skane(Residence in Baltimore: No. 1003 Harlem Ave St. 16 yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widowed (Write the word.)6-DATE OF BIRTH, Aug 7, 1871 (Month) (Day) (Year)7-AGE, 51 yrs. 9 mos. 1 ds. If LESS than 1 day, ....hrs. or....min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, None  
(b) General nature of industry, business, or establishment in which employed (or employer), None9-BIRTHPLACE, (State or Country), Italy and10-NAME OF FATHER, unknown11-BIRTHPLACE OF FATHER (State or Country), unknown12-MAIDEN NAME OF MOTHER Catherine Goldsmith13-BIRTHPLACE OF MOTHER (State or Country), England

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas J. Skane(Address) 1003 Harlem Ave

15- Robert P. Harrison,

Filed....., 191..... Registrar.

AR 9-1922 Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 8, 1922 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1922, to Mar. 8, 1922, that I saw her alive on Mar. 4, 1922, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH\* was as follows:

Diabetic Gangrene  
(Duration).....yrs.....mos.....ds.CONTRIBUTORY Diabetes Mellitus  
(Secondary) (Duration).....yrs.....mos.....ds.(Signed) P. J. Diskey M. D.  
Mar. 8, 1922 (Address) 14 N. Monroe St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New CathedralDATE OF BURIAL, 3-10, 192220-UNDERTAKER H. Branning & SonADDRESS 517 N.Schneider  
87

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62154

D 62154

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 321 W. 27th Street ST., 12 WARD)

## 2-FULL NAME

Catherine Ann Selby

## (a) RESIDENCE NO.

321 W. 27th Street

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

37

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 29, 1846

7 AGE Years Months Days 75 10 5 8 LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Prince Georges Co. (State or country) Maryland

10 NAME OF FATHER George Nelson Seaborn

11 BIRTHPLACE OF FATHER (city or town) Prince Georges Co.

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER Sarah Ann Peacock

13 BIRTHPLACE OF MOTHER (city or town) Prince Georges Co.

(State or country)

Maryland

14

Informant Daisy W. &amp; George Oden Selby (Address) 321 W. 27th Street

15

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6th 1922

17

I HEREBY CERTIFY, That I attended deceased from March 6th, 1922, to March 6th, 1922.

that I last saw him alive on March 6th, 1922.

and that death occurred, on the date stated above, at 5:35 P.M.

The CAUSE OF DEATH was as follows:

Arterio-sclerosis

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Acute indigestion

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination of organs and histology

(Signed)

M. D.

March 7th 1922

Address

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park Co.

Mar 9 1922

20 UNDERTAKER

ADDRESS

Joseph B. Cook

1663 N. Falls

9-1922



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

ROBERT P. Harrison, Registrar

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Malignancy of left testis with gonadal metastases.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) J. L. Houghton, M. D.

, 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL.

20 UNDERTAKER

ADDRESS

MAR 9 1922

Burial Permit Clerk.

TION is very important. See instructions on back of certificates.

D 62156

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE (NO.

2-FULL NAME

(Residence in Baltimore: No.

## REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. / ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE.  
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER.  
(State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER.  
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

191

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17- I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereon and from the evidence obtained by said

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

(Duration) yrs. mos. ds.

(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

3-9, 1922 (Address) 117 W. Saratoga

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Enter statement of cause of death on back of certificate. important. See instructions on back of certificate.

D 62157 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62157

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. *9* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. *5203 E. Federal* ST. *Lips* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. *1* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced, HUSBAND of (or) WIFE of *Single*6 DATE OF BIRTH (month, day, and year) *Feb. 26, 1896*7 AGE Years *26* Months *0* Days *15* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Servicing*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md.* (State or country)10 NAME OF FATHER *Joseph Mc Mahon*11 BIRTHPLACE OF FATHER (city or town) *England* (State or country)12 MAIDEN NAME OF MOTHER *Martha Hanlon*13 BIRTHPLACE OF MOTHER (city or town) *Balto Co. Md.* (State or country)14 Informant *Alma Maguire* (Address) *1203 E. Federal*15 Filed *1922* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3 - 8 - 1922*17 I HEREBY CERTIFY, That I attended deceased from *March 4, 1922*, to *March 8, 1922*, that I last saw her alive on *March 8, 1922*, and that death occurred, on the date stated above, at *7 P* m.

The CAUSE OF DEATH\* was as follows:

*Myocardial Insufficiency over*CONTRIBUTORY *Lobar Pneumonia* (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *3/9/22*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *German J. Dorf* M. D.19 (Address) *St. Joseph's Hosp*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Holy Cross Hospital Rd* *3/11/22*

20 UNDERTAKER

ADDRESS

*William Cook* *502 E. 1st*

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Probably appendicitis  
Operation for peritonitis  
Which was probably  
due to appendicitis*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62158

## CERTIFICATE OF DEATH.

D 62158

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1936 G. Chase ST.: 8 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred May Hoffman(a) RESIDENCE, No. 1936 G. Chase ST.: 8 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of W6 DATE OF BIRTH (month, day, and year) Sept. 19207 AGE Years 1 Months 6 Days    If LESS than 1 day, hrs.    or min.   

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md  
(State or country)10 NAME OF FATHER John H. Hoffman11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country)12 MAIDEN NAME OF MOTHER Jessie Garton13 BIRTHPLACE OF MOTHER (city or town) Maryland  
(State or country)14 Informant John H. Hoffman  
(Address) 11436 G Chase15 Filed R. 19 Robert P. Harrison Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 19 2217 I HEREBY CERTIFY, That I attended deceased from March 3, 1922, to March 8, 1922, that I last saw him alive on March 8, 1922, and that death occurred, on the date stated above, at 10:10 a. m.  
The CAUSE OF DEATH\* was as follows:Broncho Pneumonia

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) W. Clyde Burns M. D.8-9-22 (Address) 211 E. Pratt

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Hollywood Md. March 11, 1922

20 UNDERTAKER ADDRESS

William Cook 502 E. North Ave

TION is very important. See instructions on back of certificates.

AR 9-1922

Burial Permit Clerk

D 62159

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62159

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2044 E Hoffmann*)

WARD

## 2-FULL NAME

(a) RESIDENCE NO. *2044 E Hoffmann*

(Usual place of abode)

WARD

Length of residence in city or town where death occurred *Life* yrs. mos. ds.How long in U. S., if of foreign birth *Life* yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

COLOR OR RACE

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to March 7, 1922, that I last saw him alive on March 7, 1922.

and that death occurred, on the date stated above, at 9:25 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John T. Arcus, M. D.

, 19 (Address) 1603 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT DATE OF BURIAL

Baltimore City March 11, 1922

UNDERTAKER ADDRESS

William C. 5026 N. ...

CAUSE OF DEATH IN plain terms, so that it may be properly translated into English. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62160

## CERTIFICATE OF DEATH.

D 62160

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 Fawcett ST., 20 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth 1 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male COLOR OR RACE White Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 18 217 AGE Years 6 Months 0 Days 0 If LESS than 1 day, hrs. 0 or min. 0

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) MD10 NAME OF FATHER Thomas H. Watts11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) MD12 MAIDEN NAME OF MOTHER Willa M. Smallwood13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) MD

## PARENTS

14 Informant (Address) Thomas H. Watts  
406 Fawcett St.

## 15

19 1922 Registrar Richardson 1124 25th St

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8 192217 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1922, to Mar 8, 1922.that I last saw him alive on Mar 8, 1922.and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia  
(duration) 2 mos. 0 ds.CONTRIBUTORY (Secondary) Seeding(duration) 1 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 10 Date of 10

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Richardson  
19 22 (Address) 1124 25th St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Cathedral 3/10 192220 ADDRESS William back 502 E. Natl

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer in mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62161

D 62161

## CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 Coveal 18 St.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 219 Coveal St.; 43 yrs., mos., ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

Caf

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

March

1878

(Month)

(Day)

(Year)

7-AGE,

43

yrs., mos., ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or kind of work, particular  
(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

9-BIRTHPLACE,

(State or Country),

Baltimore City

10-NAME OF FATHER,

John Hopkins

11-BIRTHPLACE OF FATHER

(State or Country),

Md

12-MAIDEN NAME OF MOTHER

Mary Green

13-BIRTHPLACE OF MOTHER

(State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Ans Green

(Address)

219 Coveal

15-

Robert P. Harrison,

File

9-1922

191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 9, 1912

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

left 1911, to March 9, 1912

that I saw her alive on March 8, 1912

and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH\* was as follows:

Organic Disease of Heart

(Duration) yrs., mos., ds.

CONTRIBUTORY (Secondary)

(Duration) yrs., mos., ds.

(Signed)

March 9, 1912 (Address) 739 1/2 7th Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Auburn

Mar 11, 1912

UNDERTAKER

ADDRESS

R B Gross 1405 Meadey

D 62162

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62162

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No

Mercy Hospital 3

ST. WARD)

## 2-FULL NAME

Henrietta Thomas

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE. NO.

17 South High

ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed,

or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Wm Thomas

## 6 DATE OF BIRTH (month, day, and year)

Apr 26, 1897

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

24

10

15

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Va

## 10 NAME OF FATHER

William J.

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Va.

## 12 MAIDEN NAME OF MOTHER

?

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

?

## 14

Informant

(Address)

Mercy Hospital Records

Robert P. Harrison

R 9-1922

19

Permit Clerk Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 7, 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan 26, 1922

to

March 7, 1922

that I last saw her alive on March 7, 1922.

and that death occurred, on the date stated above, at 1:45 a.m.

The CAUSE OF DEATH\* was as follows:

2nd & 3rd degree Burns of thighs and buttocks  
Accidentally caused by fire  
(duration) 11 mos. 11 ds.

## CONTRIBUTORY

(Secondary)

Failure of heart (duration) 3 ds.

## 18 Where was disease contracted

If not at place of death?

German

an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John J. Gordon, M. D.

19 (Address) Mercy Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Lansing Co Va

Mar 7, 1922

## 20 UNDERTAKER

ADDRESS

P. C. Gross 1405 McEllderry

*(Charles W. Mason)*  
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62163

## CERTIFICATE OF DEATH.

D 62163

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2304 McCallish* ST. *13* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. *2304 McCallish* ST. *13* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *40* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M.*4 COLOR OR RACE *Colored*5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Oliver Mason*6 DATE OF BIRTH (month, day, and year) *1867*

7 AGE

Years *55*Months *—*Days *—*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired*(b) General nature of industry, business, or establishment in which employed (or employer) *MD*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Virginia*10 NAME OF FATHER *Charles Mason*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Virginia*12 MAIDEN NAME OF MOTHER *Mary Mason*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Virginia*

14

Informant (Address) *Mabel Mason 2304 McCallish St*

15

Filed

Feb. 19

P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/6* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *2/19*, 19 *22*, to *3/6*, 19 *22*.That I last saw him alive on *3/6*, 19 *22*.and that death occurred, on the date stated above, at *3* *PM*.

The CAUSE OF DEATH\* was as follows:

*Ch. nephritis & uremia*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Wm. R. Butler* M. D.19 (Address) *2137 8th St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 NAME OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS / 303

*James H. Dennis**Crutcher*

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

AR 9-1922

Burial Permit Clerk

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62164

## CERTIFICATE OF DEATH.

D 62164

## PLACE OF DEATH

CITY OF BALTIMORE (No. *15*)

2-FULL NAME

(Residence in Baltimore: No. *1313 N. W. Maryland St.*)

REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

Filed

191

Burial Permit Clerk.

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an

(Inquest, Autopsy or Inquiry.)

thereon and from the evidence obtained by said

(Inquest, autopsy or inquiry.)

And that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

(Coroner.)

March 9, 1922 (Address) 2802 Edmund St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS



D 62165

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62165

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1500 N. Bachel  
CITY OF BALTIMORE: (No. 1500 N. Bachel ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lolly Sunderland

(a) RESIDENCE NO. 1500 N. Bachel ST., 8 WARD  
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. 4 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Sunderland

6 DATE OF BIRTH (month, day, and year) Oct 13, 1864

7 AGE 57 Years 4 Months 24 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER Robert E. Cooper

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Maria Graser

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mrs. Mrs. Haeppel, Sister 107 Columbia St. Balt.

15 Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1919, to Mar 7, 1922.

that I last saw her alive on Mar 7, 1922

and that death occurred, on the date stated above, at 11:55 a. m.

THE CAUSE OF DEATH was as follows: Cerebral hemorrhage

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. mos. 1 1/2 ds.

18 Where was disease contracted Place of death If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Clinical

(Signed) C. W. McDonald, M. D.

(Address) 1540 N Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL London Park

20 UNDERTAKER McManis J. M. Guefel & Son 801 N. Fayette

DATE OF BURIAL

Mar 10 1922

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

99-1922

Burial Permit Clerk.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Coroner Hennessy said  
over Phone to issue  
Permit, That he had  
investigated and everything  
was alright now.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62167

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3913 Woodbine Ave

ST. 27 WARD)

2. FULL NAME Caroline Miller Hesson

(a) RESIDENCE NO. 3913 Woodbine Ave

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos.

ST. WARD (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James L. Hesson

6 DATE OF BIRTH (month, day, and year) Jan 28th, 1863

7 AGE Years 59 Months 1 Days 10 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia (State or country) Pa.

10 NAME OF FATHER Wm S. Miller

Pa.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary E. Emory

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant James L. Hesson

(Address) 3913 Woodbine Ave

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 10th 1921, to March 8th 1922, that I last saw him alive on March 8th 1922, and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Paralytic Insipidus

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine and

(Signed) A. C. Lumm M. D.

Address 4809 Gilead St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park Cemetery

20 UNDERTAKER

Burtram

DATE OF BURIAL

Mar 10-1922

ADDRESS

1723 N. Lombard St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MAR 9-1922



D 62168

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62168

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *506 N. Fremont Ave* ST.: *18* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. *506 N. Fremont Ave* ST.,

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Widowed*6a If married, widowed, or divorced HUSBAND of (or) *Wife of**Gertrude E. Nichols*6 DATE OF BIRTH (month, day, and year) *May 24, 1863*

7 AGE

*58*

Years

Months

Days

If LESS than 1 day, hrs. or min.

*10**14*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Bookkeeper 008*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Milling House*

(c) Name of employer

*Hunstrom, Lumber Co.*

9 BIRTHPLACE (city or town) (State or country)

*North Carolina*

10 NAME OF FATHER

*Dudley Nichols*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*North Carolina*

12 MAIDEN NAME OF MOTHER

*Mother Langston*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Virginia*

14

Informant (Address)

*Wm. J. Nichols 506 N. Fremont Ave*

15

Filed

*Robert P. Harrison, Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 4 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Dec. 3*, 19*21*, to *March 8*, 19*22*,that I last saw him alive on *March 8*, 19*22*,and that death occurred, on the date stated above, at *4 A.* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Nephritis*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Robt. J. Murray*, M. D.Address *516 N. Fremont Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Greenmount Cemetery 12-22*

20 UNDERTAKER

ADDRESS

*Robert Little 2700 E. Lexington Ave*

AR 9-1922

Burial Permit Clerk.

TIONS is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62169

## CERTIFICATE OF DEATH.

D 62169

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2929 Westwood Ave ST. 15 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Buchheimer(a) RESIDENCE. No. 2929 Westwood ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 6 1862

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

59 6 3

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Stone

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.10 NAME OF FATHER Geo Buchheimer

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Seamans12 MAIDEN NAME OF MOTHER Mary Buchheimer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Seamans14 Informant: Elizabeth Buchheimer (Address) 2929 Westwood Ave15 Filed ROBERT P. HARRISON, Registrar

9-1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1922

17 I HEREBY CERTIFY, That I attended deceased from

March 2 1922, to March 9 1922,that I last saw him alive on March 9 1922,and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY Chronic Arteriosclerosis (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physical signs(Signed) Herbert E. Zapp, M. D.3/9/1922 (Address) 3048 N. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

BaltimoreMar 11 1922

20 UNDERTAKER

Geo W Little

ADDRESS

2700Edmondson

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62170

D 62170

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1445 Riverside Ave* ST. *24* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Louisa Penrice Fitzgerald*

## (a) RESIDENCE. NO.

*1445 Riverside Ave* ST. *24* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*white*

5 Single, Married, Widowed, or Divorced (write the word)

*widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Mar 6. 1843*

7 AGE

*79*

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*At Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore*  
*Md.*

10 NAME OF FATHER

*Unknown*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Unknown*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Unknown*

14

Informant (Address)

*Mrs. Fitzgerald*  
*1445 Riverside Ave*

15

MAR 10 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 7- 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 12*, 19*22*, to *Mar 7-*, 19*22*, that I last saw her alive on *Mar 6-*, 19*22*, and that death occurred, on the date stated above, at *12:57* m.

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Organic Heart Disease*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis

*Physical Examination*

(Signed)

*Paul Brown*, M. D.

3/7. 1922 Address

*1837 Penna. Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Oliver Cemetery**Mar. 10 1922*

20 UNDERTAKER

ADDRESS

*E. J. Fanning & Son - 1460**Bethesda Ave.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62171

## CERTIFICATE OF DEATH.

40 D 62171

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 6 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Edna Pfeiffer

## (a) RESIDENCE. NO.

125 Jackson Place

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

1894

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

27

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

086

(b) General nature of industry, business, or establishment in which employed (or employer)

Shoe factory

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

## 10 NAME OF FATHER

Euben Kaufholz

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Ida Dornberg

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

## 14

Informant (Address)

JOHNS HOPKINS HOSPITAL

MAR 10 1922

ROBERT H. KRAUTER

Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 8<sup>th</sup> 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

March 8<sup>th</sup> 1922 to March 8<sup>th</sup> 1922that I last saw him alive on March 8<sup>th</sup> 1922and that death occurred, on the date stated above, at 11<sup>15</sup> a.m.

The CAUSE OF DEATH\* was as follows:

General Peritonitis

## CONTRIBUTORY (Secondary)

Salpingitis

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? yesDate of Mar 8 '22Was there an autopsy? yes

What test confirmed diagnosis?

(Signed)

Grant Edward M. D.

, 19

(Address)

Johns Hopkins Hospital

\*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Chel ShalomMarch 10 1922

## 20 UNDERTAKER

## ADDRESS

J. Ahrens & Co611 Madison



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Probably gonococcus  
infection.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62172

## CERTIFICATE OF DEATH.

D 62172

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital* ST. *5* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Michael Starck*(a) RESIDENCE. NO. *Old Age Home*

(Usual place of abode)

Length of residence in city or town where death occurred *115* yrs. *35* mos.

ST.

WARD.

(If nonresident give city or town and State)

ds. How long in U. S., if of foreign birth? *35* yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*m*

4 COLOR OR RACE

*w*

5 Single, Married, Widowed, or Divorced (write the word)

*married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Nov 1865*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*56**4*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Austria*10 NAME OF FATHER *Alexander Starck*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Russia*12 MAIDEN NAME OF MOTHER *Sylvia Penner*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Russia*

14

Informant (Address) *Joseph D. Starck, 3812 Park Heights Ave*

15

MAR 1 0 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/8 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*March 6, 1922, to March 8, 1922,*that I last saw him alive on *Mar 8, 1922,*and that death occurred, on the date stated above, at *11:20 p.m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral hemorrhage*(duration) *0* yrs. *0* mos. *3* ds.

CONTRIBUTORY (Secondary)

(duration) *0* yrs. *0* mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Moses S. Lellerman*, M. D.*3/8 1922* (Address) *Hebrew Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Hebrew Rosedale*

DATE OF BURIAL

*3/10 1922*

20 UNDERTAKER

*Max Linnson*ADDRESS *1127 E. Baltimore St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Enter statement on back of certificates. See instructions on back of certificates.

D 62173

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62173

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *3* WARD)

## 2-FULL NAME

(a) RESIDENCE. No. *1028 East Lombard* ST. *9* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *2* mos.

ds. How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Ralph Laforatazza*6 DATE OF BIRTH (month, day, and year) *March 20, 1897*7 AGE Years *24* Months *11* Days *9* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*(b) General nature of industry, business, or establishment in which employed (or employer) *037*

(c) Name of employer

9 BIRTHPLACE (city or town) *N. Va.* (State or country)10 NAME OF FATHER *Joseph Everhart*11 BIRTHPLACE OF FATHER (city or town) *N. Va.* (State or country)12 MAIDEN NAME OF MOTHER *Josephine Dempsey*13 BIRTHPLACE OF MOTHER (city or town) *N. Va.* (State or country)14 Informant (Address) *Mercy Hospital Records*15 *MARI 01922* ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 9, 1922*17 I HEREBY CERTIFY, That I attended deceased from *March 2, 1922* to *March 9, 1922* that I last saw him alive on *March 9, 1922* and that death occurred, on the date stated above, at *3:20 a.m.*The CAUSE OF DEATH\* was as follows: *Lobar Pneumonia*

CONTRIBUTORY (Secondary)

(duration) yrs. *10* mos. *10* ds. *Pulmonary Tuberculosis*18 Where was disease contracted *Home* if not at place of death? *Home* Did an operation precede death? *March 9, 1922*Was there an autopsy? *Yes* What was the cause of death? *John J. Coxon, M.D.* (Signed) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *St Vincent* DATE OF BURIAL *3/11 1922*20 UNDERTAKER *S. Lunsford & Bro* ADDRESS *1127 E. Baltos*

CAUSE OF DEATH is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62174

## CERTIFICATE OF DEATH.

90

D 62174

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 1 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Norton - Nortman(a) RESIDENCE. No. 503 S. Curley St. ST.  WARD. 

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth?  yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

?

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
65	--	--	--	--

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Trainman

073

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Germany

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Unknown

14

Informant

Hospital Records

(Address)

Municipal Hospital

15

MAR 10 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1922

17

I HEREBY CERTIFY, That I attended deceased from

January 12, 1922 to March 9, 1922.that I last saw him alive on March 8, 1922.and that death occurred, on the date stated above, at 9:10 A.M.

The CAUSE OF DEATH\* was as follows:

Chronic myocarditis(duration) 1 yrs. 0 mos. 0 ds.CONTRIBUTORY  
(Secondary)Myocardial infarction  
(duration) 6 yrs. 0 mos. 0 ds.18 Where was disease contracted  
If not at place of death?Had an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Aut.

(Signed)

Clyde McNeill

M. D.

3/2/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. BarnabasMar 12 1922

20 UNDERTAKER

ADDRESS

Prlos Nicolaus 2046 E. Ave

CAUSE OF DEATH in plain terms, so that it may be properly translated. See instructions on back of certificates.



D 62175

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE (NO.

ST.,

WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

7 yrs. 11 mos.

ds. How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town; State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town; State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town; State or country)

PARENTS

14

Informant (Address)

15

MAR 10 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3. 8 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 1, 1921, to March 8, 1922

that I last saw him alive on March 8, 1922

and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH\* was as follows:

Coronary of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptom

(Signed) M. D.

M. D.

3/8, 1922 (Address) 541 Fulton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park Cemetery

Mar 11 1922

20 UNDERTAKER

ADDRESS

F. B. Neppert 2236 Fred's Ave

F. B. Neppert 2236 Fred's Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62176

## CERTIFICATE OF DEATH.

179 D 62176

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 753 W. Hamburg ST., 21 WARD)

## 2-FULL NAME

Amelia Meyer

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

753 W. Hamburg ST.,

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widow

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 16 - 1857

## 7 AGE

64

Years

Months

Days

If LESS than 1 day, hrs. or min.

421

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Germany

## 10 NAME OF FATHER

Dont know

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Dont know

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

## 14

Informant (Address)

Mrs. Stephen Langholz  
1009 Bruce St

## 15

MAR 10 1922

ROBERT R. KRAUTER

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1922

## 17

I HEREBY CERTIFY, That I attended deceased from March 8, 1922, to March 9, 1922, that I last saw her alive on March 8, 1922,and that death occurred, on the date stated above, at 3<sup>10</sup> a.m.

The CAUSE OF DEATH\* was as follows:

Closure of heart  
about 2 months ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted (if not at place of death)

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed Thos. Kearney M. D.  
March 10 1922 - 3457 Puller

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Western CemeteryMarch 11 1922

## 20 UNDERTAKER

## ADDRESS

James Dignant Son1000 S. Pea

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

REVISED

C  
[Approved by]

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DR. THEO. W. KOLDEWEY  
34 S. FULTON AVENUE  
BALTIMORE, MD.

City <sup>3</sup>10/22  
Kindly change certif  
icate to 1/2 year. as this  
will conflict with  
Insurance Policy.

Mr. Werner will explain

Yours  
Dr. Koldevey

Doctor Koldevey may change the form of  
his certificate as he is the author of it. The  
change must be in red ink.

Harvard Jones  
Com. Health

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D 62177

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62177

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *North ave, Mt Washington* ST., *27* WARD)2-FULL NAME *Charles C. Homer Jr.*(a) RESIDENCE NO. *North ave, Mt Washington* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred *51* yrs. *4* mos. *22* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *W.C.* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Margaretta P. Homer*6 DATE OF BIRTH (month, day, and year) *Oct. 15<sup>th</sup> 1870*7 AGE Years Months Days If LESS than 1 day, hrs or min.  
*51* *4* *22*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Banker*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md*  
(State or country)10 NAME OF FATHER *Charles C. Homer*11 BIRTHPLACE OF FATHER (city or town) *Baltimore Md*  
(State or country)12 MAIDEN NAME OF MOTHER *Fanny Hulthaus*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore Md*  
(State or country)

14

Informant  
(Address)*Margaretta P. Homer*  
*North ave Mt Washington*

15

*MAR 10 1922*

ROBERT R. KRAUTH

Burial Permit Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 9<sup>th</sup> 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*May 20<sup>th</sup> 1921, to March 9<sup>th</sup> 1922,*that I last saw him alive on *March 8<sup>th</sup> 1922,*and that death occurred, on the date stated above, at *8:45 A.M.*

The CAUSE OF DEATH\* was as follows:

*Myocarditis with  
chronic nephritis with  
arterial hypertension*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Urinalyses*(Signed) *M. M. Dabney* M. D.*March 9<sup>th</sup> 1922* (Address) *Quinton Md*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL

*Druid Ridge Cemetery*

20 UNDERTAKER

ADDRESS

*John Ortitcheff 1201 N. Gay St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62178  
1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

89 D 62178  
REGISTERED NO. CCITY OF BALTIMORE: (No. 170 Collins Ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Bridget P. Nolan(Residence in Baltimore: No. 170 Collins AveSt.; 30 yrs., 0 mos., 0 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)  
Married

6-DATE OF BIRTH,

Jan 1, 1902  
(Month) (Day) (Year)

7-AGE,

3-5If LESS than 1 day,  
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Home and at

(b) General nature of industry, business, or establishment in which employed (or employer).

Home 031

9-BIRTHPLACE,

(State or Country),

Ireland

10-NAME OF FATHER,

Thomas Reddington

11-BIRTHPLACE OF FATHER

(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

May McTigue

13-BIRTHPLACE OF MOTHER

(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anthony Nolan(Address) 170 Collins Ave

15-

MAR 1 0 1922

ROBERT R. KRAUTER

Filed

191

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 8, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

during 1911 to 1912that I saw him alive on 1922 191and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH\* was as follows:

Angina Pectoris - severe form  
for 10 minutes + death

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Atherosclerosis

(Duration) yrs. mos. ds.

(Signed) Chas. A. Brown M. D.Feb 10, 1912 (Address) 812 West St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Peters CemMarch 11 1922

20-UNDERTAKER

ADDRESS

John E. Conran Son901 Collins St

important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62179

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital* ST.: *8* WARD)

## 2-FULL NAME

*Arthur V. Hensel*

## (a) RESIDENCE. No.

*1609 N. Castle*

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *28* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*M*

4 COLOR OR RACE

*W*

5 Single, Married, Widowed, or Divorced (write the word)

*married*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Sarah Hensel*

6 DATE OF BIRTH (month, day, and year)

*Nov 15 1884*

7 AGE

*37*

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*3**11*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Painter & Decorator*

(b) General nature of industry, business, or establishment in which employed (or employer)

*086*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore*

10 NAME OF FATHER

*Gustav Hensel*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Emma Richter*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Germany*

14

Informant  
(Address)*Mrs. Sarah L. Hensel  
1609 N. Castle St.*

15

MAR 10 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 8 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*March 4 1922, to March 8 1922*that I last saw him alive on *March 8 1922*and that death occurred, on the date stated above, at *7:30 p. m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*(duration) yrs. mos. *21* ds.CONTRIBUTORY  
(Secondary)(duration) yrs. mos. *2* ds.18 Where was disease contracted *at home*  
if not at place of death? *1609 N. Castle*

Did an operation precede death? Date of

Was there an autopsy? *yes*

What test confirmed diagnosis?

(Signed)

*Dr. J. S. Paulson*

M. D.

19 (Address)

*Hebrew Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Baltimore Co.**Mar. 11 1922*

20 UNDERTAKER

ADDRESS

*Joseph B. Cook**1003 N. Balto*

TION is very important. See instructions on back of certificates.

D 62180

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62180

## CERTIFICATE OF DEATH

1-PLACE OF DEATH *Robt Garrett Hosp for Children*  
 CITY OF BALTIMORE: (No. *27 N Carey* ST. *22* WARD)  
 2-FULL NAME *Vernon Roy Eaton*  
 (a) RESIDENCE. No. *632 W. Barre* ST. \_\_\_\_\_ WARD. \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. \_\_\_\_\_  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *single*

5a If married, widowed, or divorced  
 HUSBAND of \_\_\_\_\_  
 (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) *Mar 18 1921*  
 7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*10 18*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md*  
 (State or country)

10 NAME OF FATHER *James W. Eaton*

11 BIRTHPLACE OF FATHER (city or town) *Kent Island Md*  
 (State or country)

12 MAIDEN NAME OF MOTHER *Caroline Steinbach*

13 BIRTHPLACE OF MOTHER (city or town) *Baltimore Md*  
 (State or country)

14 Informant *Mrs James W. Eaton*  
 (Address) *632 W. Barre St*

15 MAR 10 1922

ROBERT R. KRAUTER,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 8 1922*

17 I HEREBY CERTIFY, That I attended deceased from *March 1, 1922* to *March 8, 1922*  
 that I last saw him alive on *March 8, 1922*  
 and that death occurred, on the date stated above, at *535 P. m.*

The CAUSE OF DEATH\* was as follows:

*Pneumonia & Tetany*

CONTRIBUTORY (Secondary) *Septic Media Purulent*  
 (duration) yrs. mos. ds.

18 Where was disease contracted *unknown*  
 if not at place of death?

Did an operation precede death? *no* Date of \_\_\_\_\_

Was there an autopsy? *no*

What test confirmed diagnosis? *Phys Examination*

(Signed) *J. H. Clark* M. D.  
*3/8 1922* Address *27 N Carey St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Loudon Park* *Mar 10 1922*

20 UNDERTAKER *John F. Denny* ADDRESS *715 Light St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62181

D 62181

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1045 N. Dunsen St.)

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1045 N Dunsen St.)

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH

Jan 1, 1902

7-AGE

20 yrs. 2 mos.

If LESS than 1 day,

hrs. or mins.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

MAR 1 0 1922

191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Nov 9, 1922

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

Jan 1, 1922, to Nov 9, 1922

that I saw him alive on Nov 8, 1922

and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH was as follows:

Chronic Valvular Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. E. W. M. D.

(Address) 1045 N. Dunsen St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer

DATE OF BURIAL,

Nov 13, 1922

20-UNDERTAKER

J. K. J. J. K. J.

ADDRESS

1739 Eager



D 62182

## HEALTH DEPARTMENT—CITY OF BALTIMORE, 62182

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2322 Belair Ave. ST., 8 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. 2322 Belair Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Graf

6 DATE OF BIRTH (month, day, and year) May 31st 1849

7 AGE Years 72 Months 9 Days 8 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Germany

14 Informant Mary Graf (Address) 2322 Belair Ave.

15 MART 01322 J. E. Weber Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8th 1922

17 I HEREBY CERTIFY, That I attended deceased from March 8th 1922 to March 8th 1922

that I last saw him alive on March 8th 1922

and that death occurred, on the date stated above, at 3:22 P. M.

The CAUSE OF DEATH\* was as follows:

Coronary Thrombosis over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Slight Thrombosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

Was test confirmed diagnosis? (Signed) J. E. Weber M. D.

(Address) 1501 E. Pratt St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Jerusalem Cemetery

20 UNDERTAKER

Fred L. Lassus

DATE OF BURIAL

March 12, 22

ADDRESS

Fullerton

CAUSE OF DEATH is very important. See instructions on back of certificates.

D 62183

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: 1 WARD)2-FULL NAME Otto Doring(a) RESIDENCE. No. 2403 Fleet ST., 1 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male White Widower5a If married, widowed, or divorced HUSBAND of the late Marie Doring (or) WIFE of6 DATE OF BIRTH (month, day, and year) Sept. 12-1864

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

57517

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

at Schmidt's

(c) Name of employer

Bakery

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

John Long  
2403 Fleet St.

15

Filed

MARCH 10 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8<sup>th</sup> 192217 I HEREBY CERTIFY, That I attended deceased from March 7, 1922, to March 8, 1922, that I last saw him alive on March 8, 1922, and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH\* was as follows:

Strangulated Ingu. HerniaCONTRIBUTORY (Secondary) Nephritis; Uremia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of March 8, 1922Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. C. Marino M. D., 19 (Address) St Joseph's Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer CemMarch 13 1922

20 UNDERTAKER

ADDRESS

Lilly & Green4033 Maple

CAUSE OF DEATH in plain terms, so that it may be understood by the layman. See instructions on back of certificates.

D 62184 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62184

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *4378* St. *11* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *4378* St. *11* Ward; yrs. .... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX, *7* 4-COLOR OR RACE, *W.* 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH. .... 1. .... (Month) (Day) (Year)

7-AGE, *50* yrs. .... mos. .... ds. If LESS than 1 day, .... hrs. or .... min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. .... (b) General nature of industry, business, or establishment in which employed (or employer). ....

9-BIRTHPLACE, (State or Country), ....

PARENTS. 10-NAME OF FATHER, .... 11-BIRTHPLACE OF FATHER, (State or Country), .... 12-MAIDEN NAME OF MOTHER, .... 13-BIRTHPLACE OF MOTHER, (State or Country), ....

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Police*

(Address) .....

15-

Filed

MAR 1 0 1922

Registrar. *J. E. Kuhn*

16-DATE OF DEATH

*4378* *27* *22* (Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* find that said deceased came to *death* (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Suicide*  
*by Gas*  
*Asphyxia* (Duration) yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) *Asphyxia* (Duration) yrs. .... mos. .... ds.

(Signed) *G. C. Pladed* M. D. (Address) *17376 Broadway*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, .... yrs. .... mos. .... ds. In the State, .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *Trinity, Cty.* *Mar 10*, 19 *22*

20-UNDERTAKER, ADDRESS *John C. Moran 3000 E. Baltimore*

is very important. See instructions on back of certificate.

D 62185

## HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 62185

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. *704 N Bond* St. *7* WARD)

## 2-FULL NAME

*Lawrence E. Wilson*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *704 N Bond*St.; yrs., *1* - mos. *5* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write the word.*) *Bald*

## 6-DATE OF BIRTH.

*Feb 9 1921*  
(Month) (Day) (Year)

## 7-AGE.

*1 yrs. 1 mos. 6 ds.* If LESS than 1 day, ...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Bald*  
(b) General nature of industry, business, or establishment in which employed (or employer). *off*

## 9-BIRTHPLACE, (State or Country).

*Balti*

## 10-NAME OF FATHER.

*Josiah Wilson*

## 11-BIRTHPLACE OF FATHER (State or Country).

*Balti*

## 12-MAIDEN NAME OF MOTHER.

*Lucy Smith*

## 13-BIRTHPLACE OF MOTHER (State or Country).

*Balti*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Josiah Wilson*(Address) *704 N Bond*15-*MAR 1 0 1922*

ROBERT R. KRAUTER,

Filed *191*Burial Permit *Blank*

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

*Mar 8 1922*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.)find that said deceased came to death *on the day stated above.* (Cause of death.)

The CAUSE OF DEATH\* was as follows:

*Bronchitis Pneumonia*(Duration) *1* yrs. *1* mos. *6* ds.CONTRIBUTORY (Secondary) *none*(Signed) *W. E. ...* M. D.

(Coroner)

5-5-7 1921 (Address) *W. E. ...*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *1* mos. *6* ds. In the State *1* yrs. *1* mos. *6* ds.Where was disease contracted, if not at place of death? *...*Former or usual residence *...*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

*Laurel Hill* *Mar 10 1922*20-UNDERTAKER ADDRESS *378**Samuel Newby Biddle*

CAUSE OF DEATH IN plain text, so that it may be properly entered. important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62186

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

ST., WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ST., WARD

(If non-resident, give city or town and State)

How long in U. S., if of foreign birth?

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAY 10 1922

ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from March 4, 1922, to March 10, 1922, that I last saw him alive on March 8, 1922, and that death occurred, on the date stated above, at 5 A. M.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Goldberg M. D.  
3/10, 1922 Address 2210 E. Baltimore St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 62187

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 So. Bradford

ST.,

WARD)

2-FULL NAME THEODORE MALECKI,

(a) RESIDENCE NO. 615 So. Bradford

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. II mos.

24 ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male, 4 COLOR OR RACE White, 5 Single, Married, Widowed, or Divorced, (write the word) Single,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 13/21.

7 AGE Years Months Days If LESS than 1 day, his or min. 0 II 24

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.,

10 NAME OF FATHER Joseph Malecki,

11 BIRTHPLACE OF FATHER (city or town) Baltimore, (State or country) Md.,

12 MAIDEN NAME OF MOTHER Agnes Borowska,

13 BIRTHPLACE OF MOTHER (city or town) Poland, (State or country)

14 Informant Mrs. Agnes Malecka,

(Address) 615 So. Bradford Street

15 MAR 10 1922 ROBERT R. KRAUER,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9, 1922

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1922, to March 9, 1922, that I last saw him alive on March 9, 1922, and that death occurred, on the date stated above, at 11:00 p.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) yrs. mos. 3 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. [Signature] M. D.

719. 1922 (Address) 405 S. [Signature]

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Stanislaus Cem. March 10, 1922

20 UNDERTAKER

ADDRESS

M. J. [Signature] 405 S. [Signature]

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Burial Permit Clerk

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior*

D 62188

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

Registered No. C.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 731 St. 731 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 731 St. 731 Ward)

St.; yrs., mos., ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female	4-COLOR OR RACE. white	5-Single, Married, Widowed, or Divorced. (Write the word.) Single
6-DATE OF BIRTH. March 9, 1922 (Month) (Day) (Year)		
7-AGE. yrs. mos. ds. ... hrs. or min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Dependent		

9-BIRTHPLACE.  
(State or Country)

10-NAME OF FATHER. Joseph Glab	11-BIRTHPLACE OF FATHER. (State or Country) Poland
12-MAIDEN NAME OF MOTHER. Antonina Gubala	13-BIRTHPLACE OF MOTHER. (State or Country) Poland

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

MAR 1 0 1922

ROBERT R. KRAUTER,

Burial Permit Clerk Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 9, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an inquest, autopsy or inquiry.

(Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Congenital Debility

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)(Duration) yrs. mos. ds.  
(Signed) Henry G. ... M. D.  
(Coroner.)  
1922 (Address) 1800 York St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

St. Stanislaus.

March 11, 1922.

20-UNDERTAKER.

ADDRESS

W. J. Sadowski 705 S. Ann St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62189

## CERTIFICATE OF DEATH.

160

D 62189

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1109 Riverside Ave.* ST., *24<sup>th</sup>* WARD)2. FULL NAME *Francis H. Brauman.*(a) RESIDENCE NO. *1109 Riverside Ave.* ST., *24<sup>th</sup>* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

14

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb 23 1922*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *0 0 14*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore Md.*10 NAME OF FATHER *Michael J. Brauman*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto Md.*12 MAIDEN NAME OF MOTHER *Ethel Harvey*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto Md.*14 Informant *Michael J. Brauman* (Address) *1109 Riverside Ave*15 *ROBERT R. KRAUER*

MAR 1 0 1922

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 9<sup>th</sup> 22*17 I HEREBY CERTIFY, That I attended deceased from *Mar 1, 1922* to *Mar 7, 1922* that I last saw him alive on *Mar 5, 1922* and that death occurred, on the date stated above, at *5<sup>30</sup> A. M.*

The CAUSE OF DEATH\* was as follows:

*Congenital Deblity*CONTRIBUTORY (Secondary) *from Risor* (duration) yrs. mos. ds. *1*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Glumay*(Signed) *R. H. Campbell, M. D.*(Address) *1109 Riverside Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Cedar Hill Cemetery*

20 UNDERTAKER

*E. B. Harle*

DATE OF BURIAL

*3-10<sup>th</sup> 1922*

ADDRESS

*1156 West St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 62190

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

57 D 62190  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2043 Harlem Ave

ST. 16

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Anna Malthan

(Residence in Baltimore: No. 2043 Harlem Ave

St.; 60 yrs., 10 mos. 8 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

## 6-DATE OF BIRTH,

May 1, 1861.  
(Month) (Day) (Year)

## 7-AGE,

60 yrs., 10 mos. 8 ds.

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

none 37

## 9-BIRTHPLACE,

(State or Country),

Balto.

## 10-NAME OF FATHER,

John D. Lemmerson

## 11-BIRTHPLACE OF FATHER (State or Country),

Germany.

## 12-MAIDEN NAME OF MOTHER

Do not know.

## 13-BIRTHPLACE OF MOTHER (State or Country),

Germany.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) August Malthan

(Address) 2043 Harlem Ave

## 15-

Filed..... 181 ROBERT R. KRAUTER, Registrar.

MAR 1 0 1928 Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

March 9, 1922.  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Jan 27 1922, to March 9 1922.

that I saw her alive on March 8 1922,

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH\* was as follows:

Toxaemia - diabetic gangrene  
left leg & thigh.

(Duration) yrs. mos. ds.

CONTRIBUTORY. Diabetic Mellitus.

(Secondary)

3 or 4

(Duration) yrs. mos. ds.

(Signed) M. B. Burn and Ford M. D.

March 9, 1922. (Address) 626 N. Gilman St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Baltimore Cem.

## DATE OF BURIAL,

3-11-1922.

## 20-UNDERTAKER

Mrs. Chas A G. Rohde

## ADDRESS

Arlington Ave

D 62191

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62191

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 17 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Erma Watkins(a) RESIDENCE. NO. 534 Lambert St ST. 17 WARD. 17  
(Usual place of abode)  
Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.  
(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 1880  
7 AGE Years 41 Months -- Days -- If LESS than 1 day, -- hrs. or -- min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia10 NAME OF FATHER Robert Dandridge11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia12 MAIDEN NAME OF MOTHER Ada Bowles13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia14 Informant Hospital Records,  
(Address) Municipal Hospital.15 Filed 19 ELL Registrar

MAR 10 1922

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 19 2217 I HEREBY CERTIFY, That I attended deceased from March 2, 19 22, to March 7, 19 22, that I last saw him alive on March 7, 19 22, and that death occurred, on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH\* was as follows:

Recurrent sarcoma of left breast.(duration) 3 yrs. 0 mos. 0 ds.CONTRIBUTORY Death while under ether  
(Secondary) anesthesia (duration) 3 yrs. 0 mos. 0 ds.18 Where was disease contracted —  
if not at place of death?Did an operation precede death? yes Date of 3-7-22Was there an autopsy? noWhat test confirmed diagnosis? Clinical & lab. findings(Signed) L. H. Brumbaugh, M. D.3/8/1922 Address Municipal Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Luke's Cemetery DATE OF BURIAL March 11/192220 UNDERTAKER James H. Dennis ADDRESS 303

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 62192

D 62192

## CERTIFICATE OF DEATH.

X 101-001

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 658 Dover ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Allen Garner,

## (a) RESIDENCE. NO.

658 Dover ST.

WARD.

Lynsberg N.C.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Col.

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

not known.

## 6 DATE OF BIRTH (month, day, and year)

(?)

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

about 35 yrs.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

N.C.

(State or country)

## 10 NAME OF FATHER

(?)

## 11 BIRTHPLACE OF FATHER (city or town)

(?)

(State or country)

## 12 MAIDEN NAME OF MOTHER

(?)

## 13 BIRTHPLACE OF MOTHER (city or town)

(?)

(State or country)

## 14

Informant  
(Address)Annie Garner  
658 Dover St.

## 15

Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 8<sup>th</sup> 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Mar. 6<sup>th</sup> 1922, to Mar. 8<sup>th</sup> 1922.that I last saw him alive on Mar. 8<sup>th</sup> 1922.

and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration)

yrs.

mos.

6 ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

J. H. Ramey, M. D.

3/9, 1922

Address)

140 W. Hill St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Lynsberg N.C.

## DATE OF BURIAL

Mar. 10<sup>th</sup> 1922

## 20 UNDERTAKER

R. G. Groves 1406 McElderry

MAR 10 1922

Burial Permit Clerk?

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



D 62193

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

36-002  
D 62193

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 428 N. Durham ST., 6 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Edward Wilson

## (a) RESIDENCE NO.

428 N. Durham

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 2 mos. 5 ds. How long in U. S., if of foreign birth? 13 yrs. 2 mos. 5 ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

colored

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofNone

## 6 DATE OF BIRTH (month, day, and year)

1909

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

13year Jan.8

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Maryland

## 10 NAME OF FATHER

Joe. Wilson

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Clodie Curtis

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

## 14

Informant  
(Address)Joe. Wilson  
428 N. Durham St.

## 15

Robert P. Harrison,

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-8-1922

17

I HEREBY CERTIFY, That I attended deceased from

12-31-1921, to 3-8-1922.that I last saw him alive on 3-8-1922.and that death occurred, on the date stated above, at 8:50 A.M.

The CAUSE OF DEATH\* was as follows:

Tuberculosis of bonesCONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

A. G. Gargill, M. D.3-8-1922 (Address) 611 N. Caroline

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Asbury Cemetery March 12 1922

## 20 UNDERTAKER

## ADDRESS

Milton Davis, 315 N. Eden St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement on back of certificates. See instructions on back of certificates.

R1 01922

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name organ; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Not of vertebral column*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62194

D 62194

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal HospitalST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Fickle(a) RESIDENCE. No. 322 Bethel St.

(Usual place of abode)

ST. 3 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 18677 AGE Years 54 Months -- Days -- If LESS than 1 day, hrs. -- or min. --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,  
(State or country) Maryland10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown  
(State or country)12 MAIDEN NAME OF MOTHER Mary Johnson13 BIRTHPLACE OF MOTHER (city or town) Maryland  
(State or country)14 Informant Hospital Records,  
(Address) Municipal Hospital.15 Filed ROBERT P. HARRISON,  
19 1922 Registrar

Serial Permit Clerk?

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 19 22

17 I HEREBY CERTIFY, That I attended deceased from

December 20, 1921, to March 7, 1922.that I last saw him alive on March 6, 1922.and that death occurred, on the date stated above, at 2 A.M. m.

The CAUSE OF DEATH\* was as follows:

Chronic myocarditis(duration) 5 yrs. mos. ds.CONTRIBUTORY Pneumonia  
(Secondary) (duration) 3 yrs. mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? M

What test confirmed diagnosis?

(Signed) C. E. McNeil M. D.3/7/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

Commissioner Health,

ADDRESS

MAR 10 1922

Per. Wm. E. W. W. W.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement in plain terms is very important. See instructions on back of certificates.

D 62195

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62195

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Howard(a) RESIDENCE. No. UnknownST. 76 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18817 AGE Years 40 Months -- Days -- If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown14 Informant Hospital Records,  
(Address) Municipal Hospital,15 Filed Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 192217 I HEREBY CERTIFY, That I attended deceased from March 4, 19 22, to March 7, 19 22.that I last saw him alive on March 6, 19 22.and that death occurred, on the date stated above, at 6:00 A.M.

The CAUSE OF DEATH\* was as follows:

Cerebral HemorrhageCONTRIBUTORY (Secondary) P.N.S. Syphilis (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Capt. McNeil, M. D.3/7/1922 Address Municipal Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

Commissioner Health,

ADDRESS

MAR 10 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

AR 01922

Municipal Hospital

Commissioner Health



D 62196

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

159-002  
D 62196

## PLACE OF DEATH

CITY OF BALTIMORE (No. *16* ST. *16* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*George Jos. Eagles*(Residence in Baltimore: No. *824 Calverton Rd.* St.: yrs. mos. *1* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*male*

## 4-COLOR OR RACE,

*white*5-SINGLE, *single*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

*March 3, 1922*  
(Month) (Day) (Year)

## 7-AGE,

yrs. mos. *1* ds.If LESS than 1 day,  
hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*none*  
*Infantry*9-BIRTHPLACE,  
(State or Country),*Ba. Co. Md.*

## PARENTS.

## 10-NAME OF FATHER,

*Clarence Eagles*11-BIRTHPLACE OF FATHER  
(State or Country),*Ba. Co. Md.*

## 12-MAIDEN NAME OF MOTHER

*Grace Fowler*13-BIRTHPLACE OF MOTHER  
(State or Country),*Ba. Co. Md.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Clarence Eagles*(Address) *824 Calverton Rd.*

## 15-

Filed *Robert P. Harrison*  
Registrar.

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*March 4, 1922*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest*  
(Inquest, au-*opsy* and that said deceased came to *death*  
(Autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Patient fractured*  
*neck*  
(Duration) yrs. mos. *1* ds.CONTRIBUTORY  
(Secondary)(Duration) yrs. mos. ds.  
(Signed) *J. B. Harrison* M. D.  
(Coroner.)  
*March 6, 1922* (Address) *2802 Edmondson*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the  
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

## Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

## 20-UNDERTAKER

## ADDRESS

*Commissioner Health**MAR 10 1922*

Per. Wm. E. WOODWARD

important. See instructions on back of certificate.

D 62197

## HEALTH DEPARTMENT—CITY OF BALTIMORE

b 62197

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 N. Wash ST.)

ST.

WARD) 7

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Francis C. Pfau

(Residence in Baltimore: No. 1023 N. Wash St.)

St.; yrs., mos., ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

M.

## 4-COLOR OR RACE,

W.

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

## 6-DATE OF BIRTH,

Jan 29, 1921  
(Month) (Day) (Year)

## 7-AGE,

1 yrs., 1 mos., 9 ds.

If LESS than 1 day,  
...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular  
kind of work.  
(b) General nature of industry, business, or establishment in which  
employed (or employer).

None

## 9-BIRTHPLACE,

(State or Country), Ind

## 10-NAME OF FATHER,

Francis L. Pfau

11-BIRTHPLACE OF FATHER  
(State or Country), Ind.

## 12-MAIDEN NAME OF MOTHER

Caroline Schutte

13-BIRTHPLACE OF MOTHER  
(State or Country), Ind

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Francis Pfau  
(Address) 1023 N. Washington St.

## 15-

Robert P. Harrison,

Filed

191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Mch 9, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Mch 5 1922, to Mch 9 1922.  
that I saw him alive on Mch 9 1922.

and that death occurred, on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY  
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

J. M. Fink M. D.  
Mch 10, 1922 (Address) 1823 N. Washington St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer

## DATE OF BURIAL,

Mch 11, 1922

## 20-UNDERTAKER

Geo. M. Fink &amp; Son

## ADDRESS

811 N. Wolfe St.

Important. See instructions on back of certificate.

1 01922

*No infection present*

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

*lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

*Abortion, Cellulitis, Childbirth, Convulsions, Hamorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.*

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62198

D 62198

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 Division ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William M. Cormick

(a) RESIDENCE. No. 1608 Division ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 18 79

7 AGE

Years

Months

Days

43

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER John M. Cormick

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant (Address)

Mary Callery 1608 Division St

15

Filed

Robert V. Harrison Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 24 1922 to Mar 8 1922

that I last saw him alive on Mar 7 1922

and that death occurred, on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH\* was as follows:

Acute Miliary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Tuberculin test

(Signed) Hue Brown

M. D.

3/8/22 Address 1837 1/2 Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral

Mar 11 1922

20 UNDERTAKER

ADDRESS

H.C. Wredifeld 914 Brunswick Ave

CAUSE OF DEATH is very important. See instructions on back of certificates.

01922



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Lungs involved*

D 62199

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62199

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Faubus &amp; Green

ST.:

WARD)

2-FULL NAME

Martha Woodyear

(a) RESIDENCE. NO.

New Windsor, Md

ST.:

WARD.

New Windsor Md

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

/ 4

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

? 1900

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

22 years

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House maid

(b) General nature of industry, business, or establishment in which employed (or employer)

070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Arac Woodyear

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

A. Zopf

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant (Address)

Hospital Record

15

01922

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 10 1922

17

I HEREBY CERTIFY, That I attended deceased from

1-24

1922, to 3-10

1922

that I last saw her alive on 3-10

1922

and that death occurred, on the date stated above, at 12:05 p.m.

The CAUSE OF DEATH\* was as follows:

Bilateral Bronch pneumonia

CONTRIBUTORY (Secondary)

Appendicitis &amp; peritonitis

(duration)

yrs.

mos. 14

ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

yes

Date of

Feb 7, 1922

Was there an autopsy?

Partial

What test confirmed diagnosis?

Clinical findings

(Signed)

R. P. Taylor

M. D.

, 19 (Address)

University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Chapel

March 13 1922

20 UNDERTAKER

ADDRESS

H. B. Bannard &amp; Son

Orestminster

D 62200

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62200

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

3103 - Huntington St.

ST.:

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Mrs. Missouri Jones

(Residence in Baltimore: No.

2103 Huntington St.

St.:

52

yrs., mos., ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

widow

## 6-DATE OF BIRTH.

Mar 16, 1848

(Month)

(Day)

(Year)

## 7-AGE.

74 yrs., 11 mos., 25 ds.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE. (State or Country).

Va

## 10-NAME OF FATHER.

Mr. H. White

## 11-BIRTHPLACE OF FATHER (State or Country).

Va

## 12-MAIDEN NAME OF MOTHER

Elizabeth Bailey

## 13-BIRTHPLACE OF MOTHER (State or Country).

Va

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Chas. F. Walms

(Address)

2039 W. Pratt St.

## 15-

Robert P. Harrison,

191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

March 19, 1922

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from Feb 27 1912, to Mar 9 1912, that I saw h. e. alive on Mar 9 1912, and that death occurred, on the date stated above, at 1030 P.M.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Age &amp; Debility

(Duration) yrs. mos. ds.

(Signed) John A. Cogan, M. D.

Mar 1922 (Address) 101 N. Carey

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the 52 State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

London Park

## DATE OF BURIAL.

Mar 21, 1922

## 20-UNDERTAKER

Geo. W. Little

## ADDRESS

2700 Edmonson

important. See instructions on back of certificate.

1922

Burial Permit Clerk.





D 62202

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62202

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9/3 Bimney St-ST., 1 WARD)2-FULL NAME Clifford Schulke

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 9/3 Bimney St-ST., 1 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

R 01922

Robert P. Harrison,

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

March 1, 1922, to March 9, 1922,

that I last saw him alive on March 8, 1922,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) W. W. W.

M. D.

March 9, 1922 (Address) 1014 S. Belmont Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62203

62203

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (Name of city or town)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

01922

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from

Feb 28/1922 to Nov 9/1922.

that I last saw him alive on Nov 9/1922.

and that death occurred, on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Harrison, M. D.

(Address) 1203 Light

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

William Back 5028 Nathan

CAUSE OF DEATH IN PLAIN TERMS, so that it may be understood by the jury. See instructions on back of certificates.

D 62204 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62204

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 9 Cedar St. Curtis Bay, St. 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....George Hornacek.....

15 St.; yrs.....mos.....ds.)

(Residence in Baltimore: No. 9 Cedar St. Curtis Bay, St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 4-COLOR OR RACE, 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, 7-AGE, If LESS than 1 day, yrs., mos., ds., hrs., or, min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), 10-NAME OF FATHER, 11-BIRTHPLACE OF FATHER, (State or Country), 12-MAIDEN NAME OF MOTHER, 13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Tony Patrick, (Address) 9 Cedar St. Curtis Bay, 15- Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 9th, 1922, (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above. The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis, (Duration) yrs., mos., ds.

CONTRIBUTORY (Secondary), (Duration) yrs., mos., ds., (Signed) Robert P. Harrison, M. D., (Coroner), March 10, 1922, (Address) 1217 S. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, yrs., mos., ds. In the State, yrs., mos., ds. Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Holy Cross Cemetery, March 11, 1922

20-UNDERTAKER, ADDRESS, Margaret L. Flynn, 1422 Right St.

is very important. See instructions on back of certificate.

D 62205

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 62205

## CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

510 Park Avenue

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Dr. Bennet Bernard Browne

(Residence in Baltimore: No.

510 Park Avenue

St.; 27 yrs.

mos.

ds.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

white

5-SINGLE,

MARRIED

widowed

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

June

16, 1842

(Month)

(Day)

(Year)

7-AGE

79

yrs.

8

mos.

23

ds.

If LESS than

1 day, ---hrs.

or ---min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Physician

154

9 BIRTHPLACE  
(State or country)

Queen Annes Co. Md

10-NAME OF FATHER

Charles Cochran B.

PARENTS

11-BIRTHPLACE OF FATHER  
(State or country)

Maryland

12-MAIDEN NAME OF MOTHER

Elizabeth Willson

13-BIRTHPLACE OF MOTHER  
(State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bennet Browne

(Address)

510 Park Ave

15

Robert P. Harrison,

APR 11 1922

Bennet Browne, Registrar

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

March

10

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4, 1922, to March 10, 1922.

that I saw him alive on March 10, 1922,

and that death occurred, on the date stated above, at 8 A. M.

The CAUSE OF DEATH\* was as follows:

Senile debility -  
Myocarditis

(Duration)

1

yrs.

mos.

ds.

Contributory  
(SECONDARY)

Senile debility

(Duration)

3

yrs.

mos.

ds.

(Signed)

Bennet B. Browne Jr

M. D.

March 10 1922 (Address)

Annapolis, Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Greenmount Cem

DATE OF BURIAL

3-13-1922

20-UNDERTAKER

Henry W. Jenkins &amp; Sons Co

ADDRESS

Orchard  
Mc Culloch Sts



D 62206

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

62206

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 923 Harlem ave ST. 18 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Russell Vetter

(a) RESIDENCE. NO. 923 Harlem ave ST. WARD. Anderson Ind.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 11 1914

7 AGE Years 8 Months - Days - If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Anderson Ind. (State or country)

10 NAME OF FATHER Joseph Vetter

11 BIRTHPLACE OF FATHER (city or town) Gosport Ind. (State or country)

12 MAIDEN NAME OF MOTHER Margaret E. Loftus

13 BIRTHPLACE OF MOTHER (city or town) Francisville Ind. (State or country)

## 14

Informant (Address)

Joseph Vetter 923 Harlem ave

1 1 1992

P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 11th, 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 26th, 1922, to Mar. 11th, 1922 that I last saw him alive on Mar. 10th, 1922 and that death occurred, on the date stated above, at 2:20 a. m.

The CAUSE OF DEATH\* was as follows:

Endo. Carditis of unknown duration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Varicella of about 8 days (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Indiana

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? General symptoms

(Signed) Elbridge C. Price, M. D.

, 19 (Address) 1012 Madison Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Anderson Indiana

March 12 1922

20 UNDERTAKER

ADDRESS

Leas G. Black 742 W. North ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62207

## CERTIFICATE OF DEATH.

90 D 62207

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1419 Piggs ave ST. 16 WARD)

## 2. FULL NAME

Elena Stevenson

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1419 Piggs ave

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 9 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7 4 COLOR OR RACE Negro 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

George Stevenson

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 42 Months 9 Days 7 If hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cos T

(b) General nature of industry, business, or establishment in which employed (or employer)

Domestic

(c) Name of employer

Schmidt - Wrights

9 BIRTHPLACE (city or town) (State or country)

Gene Arnold W

10 NAME OF FATHER

Samuel Eads

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Gene Arnold W

12 MAIDEN NAME OF MOTHER

Gene Arnold W

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Gene Arnold W

14

Informant (Address)

John Stevenson (son)  
1419-Piggs ave

15

Filed

Robert P. Harrison,

Registrar

Chief Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-9- 1922

17

I HEREBY CERTIFY, That I attended deceased from 11-10, 1922, to 3-10, 1922, that I last saw her alive on 9th, March, 1922, and that death occurred, on the date stated above, at 3:50 P.m.

The CAUSE OF DEATH\* was as follows:

Broken compensation  
metastasis(duration) yrs. 3 mos. 24 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 2 mos. ds.18 Where was disease contracted if not at place of death? at place of deathDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physical Ex(Signed) Walter J. J. J. M. D., 19 (Address) 1618 W - McKim St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Sumner Boring Grand May 12 1922

FUNERAL

ADDRESS

Charles Wright 364 Mary

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

R1 11922

D 62208

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001  
D 62208

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal HospitalST.: 4 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Painter(a) RESIDENCE. NO. 743 Vine St.ST., 4 WARD.(Usual place of abode)  
Length of residence in city or town where death occurred 4 yrs. 1 mos. 0 ds. How long in U. S., if of foreign birth? 1 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 19587 AGE 64 Years 54 Months -- Days -- If LESS than 1 day, -- hrs. or -- min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,  
(State or country) Maryland10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown  
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)14 Informant Hospital Records,  
(Address) 332 Municipal Hospital.15 Filed Feb. 19 1922 Registrar Harrison

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 19 2217 I HEREBY CERTIFY, That I attended deceased from March 20, 19 18, to March 9, 1922, that I last saw her alive on March 8, 19 22, and that death occurred, on the date stated above, at 4:40 A.M.  
The CAUSE OF DEATH\* was as follows:Pneumonia(duration) 3 yrs. 5 mos. 3 ds.CONTRIBUTORY  
(Secondary)(duration) 3 yrs. 5 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis?  
(Signed) Clyde McNeill, M. D.3/9/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Municipal DATE OF BURIAL March 13 19 2220 UNDERTAKER Harriet BrownADDRESS 134 Mary

See instructions on back of certificates. TION is very important.

11 1922

Burial Permit

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62209

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *824 S. Ellwood Ave.* ST., 1

WARD)

## 2-FULL NAME

*Mary L. Swayne*

## (a) RESIDENCE NO.

*824 S. Ellwood Ave.* ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Widowed*

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*George L. Swayne*

## 6 DATE OF BIRTH (month, day, and year)

*March 14, 1846*

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*75**11**25*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*At home*

(b) General nature of industry, business, or establishment in which employed (or employer)

*000*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore  
Maryland*

## 10 NAME OF FATHER

*George Williams*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Maine*

## 12 MAIDEN NAME OF MOTHER

*Carolina Forrest*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Maine*

## 14

Informant  
(Address)*Sarah L. Long  
Oxford Md.*

## 15

*Robert P. Harrison,*

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*March 19, 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from  
*Mar 4<sup>th</sup>*, 1922, to *Mar 9<sup>th</sup>*, 1922,  
that I last saw her alive on *March 9*, 1922,and that death occurred, on the date stated above, at *5:00 P. m.*

The CAUSE OF DEATH\* was as follows:

*Pneumonia*

(duration)

yrs.

mos.

*6* ds.CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

*no*

Date of

Was there an autopsy?

*no*

What test confirmed diagnosis?

*none*

(Signed)

*W. J. Gould*

M. D.

1922 (Address)

*1011 S. Ellwood Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Mount Carmel Cem.**March 14, 1922*

## 20 UNDERTAKER

## ADDRESS

*H. Sander Lous**1710 Fleet St.*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

APR 1 1922



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62210

## CERTIFICATE OF DEATH.

31 D 62210

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 S. Broadway V WARD)

## 2-FULL NAME

Ruben B. Schumacher

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

811 S. Broadway ST.

## WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Minnie E. Schumacher

## 6 DATE OF BIRTH (month, day, and year)

Oct 20, 1895

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

26417

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk. 809

(b) General nature of industry, business, or establishment in which employed (or employer)

Biggs Store

(c) Name of employer

Parent

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

## 10 NAME OF FATHER

John Schumacher

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Katherine Becker

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Md.

## 14

Informant (Address)

Minnie E. Schumacher  
811 S. Broadway

## 15

1922

Robert B. Harrison,  
19

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 9, 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan 10, 1922 to March 9, 1922.that I last saw him alive on March 9, 1922.and that death occurred, on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration)

yrs. 2 mos. 28 ds.

## CONTRIBUTORY (Secondary)

Rheumatic Carditis

(duration)

yrs. 2 mos. 28 ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? no

Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Rehberger M. D.19 (Address) 1709 Atlantic Ave. St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

W. Sander Sons

## ADDRESS

1709 Dead St.

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

D 62211

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62211

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1106 Mc Donough St.* 8 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. *1106 Mc Donough St.* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *140* yrs. mos. ds. How long in U. S., if of foreign birth? *37* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*5a If married, widowed, or divorced, HUSBAND of (or) WIFE of *Charles F. Leitz*6 DATE OF BIRTH (month, day, and year) *Sept. 5<sup>th</sup> 1884*7 AGE Years *90* Months *6* Days *9* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *John Kistner*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Vigonia*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

## 14

Informant (Address) *Margaret Oakhart 1112 W. Patterson Rd. Ar.*

## 15

*Robert P. Harrison,*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 9<sup>th</sup> 1922*17 I HEREBY CERTIFY, That I attended deceased from *Mar. 4, 1922* to *Mar. 9, 1922* that I last saw him alive on *Mar. 9, 1922*and that death occurred, on the date stated above, at *6 P* m.

The CAUSE OF DEATH\* was as follows:

*mitral Regurgitation*(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physiocal*(Signed) *J. E. Donovan* M. D.Address *4972 1531 E. North Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS *2016**Philip Sternig**Oleander*

MAR 11 1922

CAUSE OF DEATH in plain terms, so that it may be properly understood, is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62212

D 62212

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

516 N. Curley

CITY OF BALTIMORE: (No.

516 N. Curley

ST.: 7 WARD)

2-FULL NAME

Louisa Schindler

(a) RESIDENCE. NO.

516 N. Curley

ST.: WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

50 yrs.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Jos. Schindler

6 DATE OF BIRTH (month, day, and year)

Nov. 2, 1859

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

59

4

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Housework

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Franz Apple

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Doris-

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Freida Schindler  
516 N. Curley St.

15

Filed

19

Registrar

1 1922

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 9 1922

17 I HEREBY CERTIFY, That I attended deceased from

Feb 22, 1922, to March 8, 1922.

that I last saw her alive on March 8, 1922.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Fatty Degeneration of Heart

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 20 ds.

Bronchial Pneumonia

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Clinical

(Signed) C. C. Cooper, M.D.

3/9, 1922 Address 1400 E. Baltimore St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Mt. Lem

Mar. 11 1922

20 UNDERTAKER

Philip Sturiz

ADDRESS

2016 Orleans St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE 62213

D 62213

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2007 McHenry ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. 2007 McHenry ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. 9 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 20, 1894

7 AGE Years 46 Months 9 Days 28 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md. Conestoga School

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Cor. F. Hoffman St. 2007 McHenry St.

15 Robert F. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9, 1922

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1920, to March 9, 1922, that I last saw her live on March 9, 1922, and that death occurred, on the date stated above, at 10 00 m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Liver Metastatic to lungs Carcinoma of Breast (duration) yrs. 2 yrs.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date March 3, 20

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Howard W. Jahn, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS F. B. Huppert 2236 Freda St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

R1

1922



D 62214

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62214

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1604 Ruxton Ave. ST.

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

James D. Doherty or Dougherty

(Residence in Baltimore: No.

1604 Ruxton Ave

St.: 52 yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

Male

## 4-COLOR OR RACE,

White

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)  
Married

## 6-DATE OF BIRTH,

August 28, 1870  
(Month) (Day) (Year)

## 7-AGE,

52 yrs. 7 mos. ds.

## If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).Postal Clerk  
009

## 9-BIRTHPLACE,

(State or Country),

Baltimore Md

## 10-NAME OF FATHER,

Edward Doherty

## 11-BIRTHPLACE OF FATHER

(State or Country),

Ireland

## 12-MAIDEN NAME OF MOTHER

Mary Burns

## 13-BIRTHPLACE OF MOTHER

(State or Country),

Ireland

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mollie Doherty

(Address) 1604 Ruxton St.

## 15-

Filed Robert P. Harrison, 191

Registrar.

11 1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

March 10, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

February 18, 1922, to March 10, 1922,

that I saw him alive on March 9, 1922,

and that death occurred, on the date stated above, at 9 A. M.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage  
and acute Uræmia

(Duration) yrs. 6 mos. ds.

## CONTRIBUTORY

(Secondary)

(Duration) yrs. 1 mos. ds.

(Signed) R. P. Harrison, M. D.

March 10, 1922 (Address) 1823 Ruxton Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

St. Peter's Church

March 13, 1922

## 20-UNDERTAKER

## ADDRESS

John Howard & Son  
Jersey City, N. J.John Howard & Son  
501-

important. See instructions on back of certificate.

monia, unqualified, is indefinite); Tuberculosis of (1) mancea), whether death is directly or indirectly due to the same.

I hereby certify that on this 15th day of April, 1922, the subscriber, Mollie L. Dougherty personally appeared before me, a Notary Public of the State of Maryland and took oath that the James Doherty in the Death Certificate on file in the Health Department of Baltimore City is the same as James Dougherty.

Witness my hand and notarial seal

Harry M. Selberman  
Notary Public

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62215

D 62215

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *112 N. Carlton* ST., *18* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Baby Lewis*(a) RESIDENCE NO. *112 N. Carlton* ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced, (write the word) *Infant*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *March 9, 1922*

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Maryland*10 NAME OF FATHER *Benjamin Lewis*11 BIRTHPLACE OF FATHER (city or town) *Ann Arundel, Md.* (State or country)12 MAIDEN NAME OF MOTHER *Anna Gibbs*13 BIRTHPLACE OF MOTHER (city or town) *Montgomery Co. Md.* (State or country)

14

Informant (Address)

15 *Robert P. Harrison*

Filed

19

Burial Permit Clerk

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 9, 1922*17 I HEREBY CERTIFY, That I attended deceased from *March 9, 1922* to *March 9, 1922*, that I last saw her alive on *March 9, 1922*, and that death occurred, on the date stated above, at *8:58 am*.

The CAUSE OF DEATH\* was as follows:

*Prenatality*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Examination*(Signed) *J. J. Rigney*, M. D.19 (Address) *University Hospital*

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Commissioner Health,*

MAR 10 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 62216

D 62216

## CERTIFICATE OF DEATH.

31  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1239 Cleveland ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

WARD

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 12 1892

7 AGE Years 30 Months 26 Days 26 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) job

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Jm C Malinowski

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Anna Engel

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

## PARENTS

14 Informant (Address) Jm C Malinowski 1239 Cleveland St

## 15

Filed

Robert F. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov., 1921, to Mar 10, 1922.

that I last saw him live on Mar 10, 1922.

and that death occurred, on the date stated above, at 5:15 P. M.

The CAUSE OF DEATH\* was as follows:

Phthisis, Pul.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? None Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John G. Schumaker, M.D.

1120 W. 10th St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Linden Park

Mar 13/ 1922

20 UNDERTAKER

ADDRESS

Wm. Cook

502 E. North Ave

1 1922

Burial Permit Clerk



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62217

## CERTIFICATE OF DEATH.

D 62217

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 423 Furrow St. ST. 20 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Catherine Spahn

## (a) RESIDENCE No.

423 Furrow St.

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. 0 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of Anton Spahn6 DATE OF BIRTH (month, day, and year) Feb. 19<sup>th</sup> 18807 AGE Years Months Days If LESS than 1 day, hrs. or min.  
42 0 18

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Md.

10 NAME OF FATHER Sebastian Heinmiller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Damm

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14

Informant Adam S. Heinmiller  
(Address) 3107 Strickland St.

15

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 9<sup>th</sup> 19 22

17 I HEREBY CERTIFY, that I attended deceased from March 2, 1922, to March 9, 1922, that I last saw him live on March 9, 1922,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH was as follows:

Broncho pneumonia

CONTRIBUTORY  
(Secondary)18 Where was disease contracted  
if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinical

(Signed) M. B. Strickland, M.D.

Mch. 1922 (Address) 682 Columbia St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral Cem.

DATE OF BURIAL

Mar. 13, 1922

20 UNDERTAKER

Joseph B. Cook

ADDRESS

203 N. E. St.

CAUSE OF DEATH is very important. See instructions on back of certificates.

RI 1 1922

D 62218 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62218

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Blake(a) RESIDENCE. NO. 1321 Upton st.ST. 17 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

How long in U. S., if of foreign birth? yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 19037 AGE Years 19 Months Days If LESS than 1 day. hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hou sew ork

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia  
(State or country) Pennsylvania10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Unknown12 MAIDEN NAME OF MOTHER Mary Blake13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Unknown14 Informant Hospital Records(Address) M.T.H.15 Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8, 19 2217 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 19 22, to March 8, 19 22, that I last saw her alive on March 7, 19 22, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(duration) 1 yrs. 6 mos. ds.CONTRIBUTORY Psoas Abscess  
(Secondary)(duration) yrs. 2 mos. ds.18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray(Signed) Francis D. Dadda, M. D.3-8-22 (Address) Municipal Tbc. Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Na DATE OF BURIAL20 UNDERTAKER Tephanian ADDRESS 76Dr. E. E. E.P. O. A.

Physicians should state EXACTLY. PHYSICIANS should be stated EXACTLY. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 11 1922

D 62219

Spec.—6-9-19—H. P. Co.—1000 Bks.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

✓ D 62219

74-001

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 Sarah Ann ST.: 18 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Fisher(a) RESIDENCE. NO. 1120 Sarah Ann ST. 18 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX mm4 COLOR OR RACE col5 Single, Married, Widowed, or Divorced (write the word) married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sam's Fisher6 DATE OF BIRTH (month, day, and year) —7 AGE 49

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic(b) General nature of industry, business, or establishment in which employed (or employer) —(c) Name of employer —9 BIRTHPLACE (city or town) (State or country) Virginia10 NAME OF FATHER Samuel Ransom11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia12 MAIDEN NAME OF MOTHER Rebecca Ransom13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14

Informant (Address) Daniel Earles  
916 6th St

Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8 19 22

17

I HEREBY CERTIFY, That I attended deceased from Mar 5, 19 22, to Mar 8, 19 22.that I last saw her alive on Mar 8, 19 22.and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH\* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? Physical Exam(Signed) Ransom Ransom, M. D., 19 (Address) 1016 6th St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

4th Auburn CemMarch 12, 1922

20 UNDERTAKER

ADDRESS 916 6th St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62220

## CERTIFICATE OF DEATH.

31 D 62220

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No.

St.; 38 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

## 4-COLOR OR RACE,

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

## 7-AGE

If LESS than 1 day,  
....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular  
kind of work.....  
(b) General nature of industry, busi-  
ness, or establishment in which  
employed (or employer).....9-BIRTHPLACE,  
(State or Country),10-NAME OF  
FATHER,11-BIRTHPLACE  
OF FATHER  
(State or Country),12-MAIDEN NAME  
OF MOTHER13-BIRTHPLACE  
OF MOTHER  
(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

## 15-

Robert P. Harrison,

Filed

11 1922

Burial

P. P. Clark

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Mar 7 1922, to Mar 9 1922,

that I saw her alive on Mar 9 1922,

and that death occurred, on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Harry J. Brown, M. D.

Mar 10, 1922 (Address) 1501 Restaurant

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

## 20-UNDERTAKER

## ADDRESS

important. See instructions on back of certificate.



D 62221

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62221

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1501 Webster

ST. 24 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME John T. Baldwin

(a) RESIDENCE NO. 1501 Webster  
(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Widower

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 15 1830

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
91 4 24

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Switchman (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

B &amp; O. R. R.

9 BIRTHPLACE (city or town)  
(State or country)

Anna Arundel CO. Md.

10 NAME OF FATHER Thomas Baldwin

11 BIRTHPLACE OF FATHER (city or town)

Md.

12 MAIDEN NAME OF MOTHER Mary Cole

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md.

14

Informant Mrs. John Wilson  
(Address) 1501 Webster St.

15

11 1922 Robert P. Harrison, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/9/ 1922

17 I HEREBY CERTIFY, That I attended deceased from

1-1-1912, 19 to 19

that I last saw him alive on 3-8-22, 19

and that death occurred, on the date stated above, at 12:30 A. M.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Philip D. Tawler, M. D.

3-9-1922 (Address) 1432 William St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Louden Park Cemetery

3/11/ 1922

20 UNDERTAKER

ADDRESS

E. J. Fanning, 1460 Battery Ave.

D 62222

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62222

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE (No. *1409 Bump*)ST. *15* WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*Sarah Powell*(Residence in Baltimore: No. *1409 Bump St.*)St. *30* yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>Female</i>	4-COLOR OR RACE. <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <i>Married</i> (Write the word.)
6-DATE OF BIRTH. <i>November 1866</i> (Month) (Day) (Year)		
7-AGE. <i>56</i> yrs. mos. ds. If LESS than 1 day, ...hrs. or...min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>Laundress</i> (b) General nature of industry, business, or establishment in which employed (or employer). <i>041</i>		
9-BIRTHPLACE. (State or Country). <i>Maryland</i>		
PARENTS.	10-NAME OF FATHER.	
	11-BIRTHPLACE OF FATHER (State or Country). <i>Unknown</i>	
	12-MAIDEN NAME OF MOTHER	
	13-BIRTHPLACE OF MOTHER (State or Country).	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Rosie Helligan*(Address) *1107 N. Park St.*

15-

Robert P. Harrison,

Filed. *191* Registrar.

Special Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *March 8, 1902*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, Autopsy or Inquiry.) And that said deceased came to *his* death on the *day* stated above.  
The CAUSE OF DEATH\* was as follows:*Cerebral Hemorrhage*  
(Duration) ... yrs. ... mos. ... ds.CONTRIBUTORY *arterio-sclerosis*  
(Secondary)(Signed) *J. P. Harrison* M. D.  
(Coroner.)*March 10, 1902* (Address) *2802 Channing St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the  
of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

*Mt Zion* *Mar - 11 1902*

20-UNDERTAKER, ADDRESS

*Edward Ruggold* *1463 Carey St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE 091 62223

D 62223

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *219 S High* ST., *3* WARD)

## 2. FULL NAME

(a) RESIDENCE NO. *219 S High* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Infant

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 5-1920

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Balt

10 NAME OF FATHER

Gennaro Rizzo

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Italy

12 MAIDEN NAME OF MOTHER

Mary Lendolfo

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Italy

14

Informant  
(Address)Gennaro Rizzo  
219 S High

11 1922

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 10 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 7, 1922, to March 11, 1922.

that I last saw him alive on

March 11, 1922.

and that death occurred, on the date stated above, at

7:00 m.

The CAUSE OF DEATH\* was as follows:

Bronchitis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. J. McManus, M. D.

(Address)

1414 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

St. Vincent's Cem  
Hendel & Poppel  
378 N. Howard

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62224

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *River View av. Colegate Rd.*)2-FULL NAME *Edward Nelson Coffey.*(a) RESIDENCE. NO. *River View av & 5th St*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

14

ds.

How long in U. S., if of foreign birth?

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

*(Nelson Co. Va.)*WARD. *26.*

(If nonresident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1882, May 1st*7 AGE Years *39* Months *10* Days *10* If LESS than 1 day, hrs. or min.

8 OCCUPATION OR DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER *Geo. M. Coffey*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *Julia A. Monroe*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19 *Robert P. Harrison,*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 10 1922*17 I HEREBY CERTIFY, That I attended deceased from *Mar 10, 1922*, to *Mar 10, 1922*, that I last saw *him* alive on *Mar 10, 1922*, and that death occurred, on the date stated above, at *11 P. M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Valvular Heart Disease*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

TION is very important. See instructions on back of certificates.

1922

Burial Permit Clerk



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62225

## CERTIFICATE OF DEATH.

REGISTERED NO. C

D 62225

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10164 Patterson Pk 8

ST.: 8

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME Anthony Javoz

(Residence in Baltimore: No. 10164 Patterson Pk 8

St.: yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Mar 10, 1912 (Month) (Day) (Year)

7-AGE, If LESS than 1 day, 1. hrs. or 30 min. 7 yrs. mos. ds.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Infant (b) General nature of industry, business, or establishment in which employed (or employer) ood

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, Anthony Javoz

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Mary Beley

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anthony Javoz

(Address) 10164 Patterson Pk 8

15-

Filed. Robert P. Harrison, 191. Registrar.

1 1922

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 10, 1922 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Mar 10 1922, to Mar 10 1922, that I saw him alive on Mar 10 1922, and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. H. Williams, M.D. 3/11/22, 191... (Address) 801 N. ...

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Holy Redeemer Mar 11, 1922

20-UNDERTAKER, Address, 1906 Ashwood



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 62227

JOHNS HOPKINS HOSPITAL

ST. 7

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Audrey Cross

(a) RESIDENCE. NO.

Towson

ST.

WARD.

Maryland

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

vs. unknown

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 20, 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Walter C. Cross

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Essie Hawkins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

England

14

JOHNS HOPKINS HOSPITAL

Informant

(Address)

15

MAR 12 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 11, 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 8, 1922, to March 11, 1922,

that I last saw him alive on March 11, 1922,

and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis, pulmonary

(duration) yrs. mos. ds.

unknown

CONTRIBUTORY (Secondary)

Tuberculous meningitis

(duration) yrs. mos. ds.

17 ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Smear &amp; culture

(Signed) Horace G. Stewart, M. D.

3/11/22 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mr. Marie Cross

Mar 12, 1922

20 UNDERTAKER

ADDRESS

Johny Burns Sons Towson

TION is very important. See instructions on back of certificates.





## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62229

## CERTIFICATE OF DEATH.

31 D 62229

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1820 McHenry St. 19 WARD)2-FULL NAME Henry Solomon

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1820 McHenry St. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ds. How long in U. S., if of foreign birth 30 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Solomon6 DATE OF BIRTH (month, day, and year) July 2 - 18877 AGE Years 34 Months 8 Days 9 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery(b) General nature of industry, business, or establishment in which employed (or employer) Store 034

(c) Name of employer

9 BIRTHPLACE (city or town) Russia (State or country)10 NAME OF FATHER Samuel Solomon11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)12 MAIDEN NAME OF MOTHER Anna Solomon13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)14 Informant Jack Lewis (Address) 1439 E. Baltimore St.15 MAR 12 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/11 1922

17 I HEREBY CERTIFY, That I attended deceased from

Nov. 1921, to March 11, 1922.that I last saw him alive on March 10, 1922.and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto.Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? positive sputum(Signed) Jack Lewis, M. D.3-11-22 (Address) 223 S. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Hebrew Friendship Cem 3/12 1922

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

D 62230

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62230

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST.: 3 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Nora Carroll

## (a) RESIDENCE. NO.

218 S. Caroline

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

unknown ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Abraham Carroll

6 DATE OF BIRTH (month, day, and year)

1885

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

27

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Abraham

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

P

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia14 Informant JOHNS HOPKINS HOSPITAL

(Address)

15 Filed

MAR 12 1922ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11th 19 2217 I HEREBY CERTIFY, That I attended deceased from March 9th, 19 22, to March 11th, 19 22, that I last saw her alive on March 11th, 19 22, and that death occurred, on the date stated above, at 4:10 P. M.

The CAUSE OF DEATH\* was as follows:

Bilateral lobar pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Puerperium

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 218 S. Caroline StDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Sputum exam(Signed) E. G. G. Andrews, M. D.19 (Address) Johns Hopkins Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL

Westmoreland

DATE OF BURIAL

3/11/22 19

20 UNDERTAKER

Jack Lewis 439 S. Balto St

ADDRESS

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Child 3 days old.*  
*Phy. thinks primary*  
*cause of woman's*  
*death was pneumonia.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 19 WARD)

2-FULL NAME

Sadie Fiddle

(a) RESIDENCE. NO.

400 N. Stucker ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. life mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Julius G. Fiddle

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Annie Fiddle

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

MARI 2-1822ROBERT R. KRAUTER

Bureau Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 11, 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 5, 1922, to March 11, 1922that I last saw him alive on March 11, 1922and that death occurred, on the date stated above, at 3:20 a.m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

HomeDid an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Horace G. Stewart, M. D.3/11, 1922 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Rehearsal3/11/22

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E. Baltimore

TION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62232

## CERTIFICATE OF DEATH.

D 62232

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3001 Frederick Ave. ST. 5 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Frank Chiappetta

## (a) RESIDENCE NO.

500 Ensor Street

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos.

ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 6a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Lomisa Chiappetta

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.

40

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Italy

## 10 NAME OF FATHER Unknown

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Italy

## 12 MAIDEN NAME OF MOTHER Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Italy

## 14

Informant J. Lewis

(Address) 1411 E. Balto. St.,

MARI 2 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) March 10 1922

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1922, to March 10, 1922.

that I last saw him alive on March 10, 1922.

and that death occurred, on the date stated above, at 8:20 p.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia lob.

(duration)

yrs.

mos

5

ds.

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos

2

ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 3/10/22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Lee

M. D.

3/11, 1922 (Address) 1411 E. Balto. St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Parkwood Cem

3/12 1922

## 20 UNDERTAKER

## ADDRESS

J. Lewis 1411 E. Balto. St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62233

## CERTIFICATE OF DEATH.

REGISTERED NO. C

46 D 62233

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

953 N Duncan

ST. 7

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Katerina Mala

MALA

(Residence in Baltimore: No.

953 N Duncan

St. 18 yrs. mos. de.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE

White

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

## 6-DATE OF BIRTH,

October 1, 1912

(Month)

(Day)

(Year)

## 7-AGE,

42

If LESS than 1 day,

...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Homemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9-BIRTHPLACE, (State or Country),

Czechoslovakia

## 10-NAME OF FATHER,

John Dolezal

## 11-BIRTHPLACE OF FATHER, (State or Country),

Czechoslovakia

## 12-MAIDEN NAME OF MOTHER,

Unknown

## 13-BIRTHPLACE OF MOTHER, (State or Country),

Unknown

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Dolezal

(Address) 953 N Duncan

MAR 12 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

March 10, 1922

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Jan 10 1922 to March 10 1922

that I saw him alive on March 9 1922

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH\* was as follows:

Coronary artery disease (operated)

(Duration) 7 yrs. 4 mos. 1 ds.

CONTRIBUTORY. Asthma

(Duration) 1 yr. 1 mos. 1 ds.

(Signed) F. T. Ruzicka, M. D.

3-12-1922, 191. 22 (Address) R.R. R. Pott P. P. P.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer

## 20-UNDERTAKER,

Frank Crachin

## DATE OF BURIAL,

Mar. 12, 1922

## ADDRESS

Michaeland

important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62234

D 62234

1-PLACE OF DEATH

Boy View Hospital

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE NO.

ST. WARD)

2-FULL NAME

Peter Nicholas

(a) RESIDENCE. No.

1626 Aliceanna

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Unknown

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

White

5 Single, Married, Widowed,

Divorced (write the word)

Married

6a If married, widowed, or divorced

HUSBAND of

(or WIFE of)

Frances Nicholas

6 DATE OF BIRTH (month, day, and year)

1894

7 AGE

28.

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Greece

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Boy View Hospital Baltimore, Md.

15

Filed

MAR 12 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10, 1922

17 I HEREBY CERTIFY, that I attended deceased from Sept. 4, 1921, to March 10, 1922, that I last saw him on March 10, 1922, and that death occurred, on the date stated above, at 5:20 P.M. The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency

Residual Encephalitis (duration) yrs. mos. ds. CONTRIBUTORY (duration) yrs. mos. ds. Leukemia

18 Where was disease contracted? If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) N. J. Adams, M.D.

3/11/22 (Address) Boy View Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Woodlawn Cem

DATE OF BURIAL

3-13 1922

20 UNDERTAKER

Robert Brooks &amp; Son

ADDRESS

Cotton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62235

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Cordova Apt* ST. *13* WARD)2-FULL NAME *Sophia Lewyt Ross*(a) RESIDENCE NO. *Cordova apt*

(Usual place of abode)

Length of residence in city or town where death occurred *1 yr 11 mos.*ST. *13* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Joseph A Ross*6 DATE OF BIRTH (month, day, and year) *Mar 14 / 1848*7 AGE Years *73* Months *11* Days *23* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife 037*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *Solomon H. Lewyt*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Holland*12 MAIDEN NAME OF MOTHER *Sarah Iron*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Holland*14 Informant *M. Ross* (Address) *Cordova apt*

15

MAR 12 1922

ROBERT K. KRAUTER,

Burial Permit Officer

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 9 1922*17 I HEREBY CERTIFY, That I attended deceased from *Sept 12, 1917* to *Mar 9th, 1922*, that I last saw her alive on *Mar 8th, 1922*, and that death occurred, on the date stated above, at *715a m.* The CAUSE OF DEATH\* was as follows:*Aortic Aneurism with Cardiac Insufficiency* (duration) *4* yrs. *6* mos. *ds.*CONTRIBUTORY (Secondary) *Pulmonary Edema* (duration) *10* yrs. *10* mos. *ds.*18 Where was disease contracted if not at place of death? *no*Did an operation precede death? *no* Date of *no*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Gustav Solomon* M. D.19 (Address) *456 N Franklin St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Balt, Hebrew* DATE OF BURIAL *Mar 12 1922*20 UNDERTAKER *David Souders*ADDRESS *28 N W 42nd St*



D 62236

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62236

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

1412 Park Ave

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mary M. Latane

## (a) RESIDENCE

1412 Park Ave

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single-Married, Widowed, or Divorced (write the word)

Widow

## 5a If deceased widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

May 4 1837

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

84

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Va

## 10 NAME OF FATHER

John J. Holladay

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

## 12 MAIDEN NAME OF MOTHER

Jula M. Minor

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

## 14

Informant (Address)

James G. Latane 1412 Park Ave

## 15

MAR 12 1922

ROBERT R. KELLER Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 10 1922

## 17

HEREBY CERTIFY, that I attended deceased from

July 15 1922 to March 10 1922

that I last saw him alive on March 10 1922.

and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH\* was as follows:

Cardiac dilatation  
Pulmonary edema

Arteriosclerosis - 3 yrs. 3 ds.

CONTRIBUTORY (Secondary) Coronary Arteritis - Several yrs. - mos. - ds.

(duration) yrs. - mos. - ds.

## 18 Where was disease contracted if not at place of death?

No Date of None

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis? Discussion + Auscultation

(Signed) J. M. D.

3/11, 1922 Address) Baltimore, Md

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Richmond Va

March 13 1922

## 20 UNDERTAKER

## ADDRESS

Henry Jenkins &amp; Son Co

Richard McCallister

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62237

## CERTIFICATE OF DEATH.

89 D 62237

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

1602 E Fayette

ST.:

WARD)

## 2-FULL NAME

Wilhelmine L. Hasselbach

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

1602 E Fayette

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Friedrich A. Hasselbach

6 DATE OF BIRTH (month, day, and year)

Dec 25, 1850

7 AGE

71

Years

2

Months

16

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Luthe

PARENTS

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Luthe

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

Albert J. Hasselbach  
1602 E Fayette

15

MAR 12 1922

ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 2, 1919, to Mar 10, 1922,

that I last saw him alive on Mar 10, 1922,

and that death occurred, on the date stated above, at 9:20 a.m.

The CAUSE OF DEATH\* was as follows:

Angina Pectoris

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Richard C. Keeling, M. D.

, 19 (Address) 1514 Station St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Immanuel Cemetery

ADDRESS

20 UNDERTAKER

Louis Fleemann 323 Broadway

D 62238

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62238

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 516 P. 3rd St. 3 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Auguste Louis Feig(Residence in Baltimore: No. 516 P. 3rd St.; yrs. 60 mos. 5 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced. Widowed  
(Write the word.)6-DATE OF BIRTH. Sept 29 1860  
(Month) (Day) (Year)7-AGE. 61 yrs. 5 mos. 8 ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. Ex 16000  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country). Baltimore Md10-NAME OF FATHER. John Berger11-BIRTHPLACE OF FATHER, (State or Country). Germany12-MAIDEN NAME OF MOTHER. Christina Kaefer13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Berger(Address) 516 P. 3rd

15-

MAR 12 1922 ROBERT R. KRAUTER, Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 10 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
a papery

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shelly Feig yrs. mos. ds.(Signed) Wm. H. Charles M. D.  
(Coroner) March 11 1922 (Address) 604 E. Lomb

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Goodman Park March 13

20-UNDERTAKER. ADDRESS

Louis Fleemann 32 S Broadway

is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62239

D 62239

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1722 N Lexington ST., 19 WARD)

## 2. FULL NAME James F. Crandell

(a) RESIDENCE NO. 1722 N. Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Cecilia F. O'Padyke Crandell

6 DATE OF BIRTH (month, day, and year)

March 25-1860

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

62

11

17

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Grocery Storekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Proprietor

9 BIRTHPLACE (city or town) (State or country)

Churchtown Md

10 NAME OF FATHER

J. M. Crandell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Phippo

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Mrs. James Crandell 1722 N. Lexington St

15

MAR 12 1922

ROBERT R. KRAUTER Registrar

Bacial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/11 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1922, to March 11, 1922.

that I last saw him alive on March 10, 1922.

and that death occurred, on the date stated above, at 10:55 a.m.

The CAUSE OF DEATH\* was as follows:

Malignant Cancer of the Rectum

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. F. Hooking M. D.

19 (Address) 5835 York Road

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Presbyterian Cemetery (Central)

3/14 1922

UNDERTAKER

ADDRESS

William Cook

502 E North Ave



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person. Irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Originated on back*

D 62240 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62240

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 W Laurel ST., 16 WARD)

## 2. FULL NAME

Willard Willmore Parsons

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1006 W Laurel ST.,

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

M

## 4 COLOR OR RACE

W

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Dec 4 1855

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

66

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

OOD

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Balt

## 10 NAME OF FATHER

Theodore Parsons

## 11 BIRTHPLACE OF FATHER (city or town)

MD

## 12 MAIDEN NAME OF MOTHER

Rosanna Parsons

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

## 14

Informant

(A.M.V.)

Mrs Samuel R. Fogel

## 15

Filed

19

MAR 12 1922ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Mar 11 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

June 6 1922, to March 11 1922.that I last saw him alive on March 11 1922.and that death occurred, on the date stated above, at 3 15 p m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis (acute)

(duration) yrs. 2 mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

At Place of birthDid an operation precede death? No Date of NoWas there an autopsy? No

What test confirmed diagnosis?

(Signed) John J. Hering M. D., 19 (Address) 1425 Euter Place

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Charles

## 20 UNDERTAKER

Wm. Cook

## DATE OF BURIAL

Mar 13 1922

## ADDRESS

St. Charles

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62241

## CERTIFICATE OF DEATH.

D 62241

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4514 Weitzel

## 2-FULL NAME Margaret West

(a) RESIDENCE NO. 4514 Weitzel

(Usual place of abode)

Length of residence in city or town where death occurred

life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,

or Divorced (circle the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town,  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town,  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town,  
(State or country)

PARENTS

14

Informant

(Address)

15

File

MAR 12 1922

ROBERT N. KRAUTER,

Burial Permit Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1922

17 I HEREBY CERTIFY, That I attended deceased from  
July 1921, to March 10 1922,  
that I last saw him alive on March 10 1922,  
and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH\* was as follows:

Coronary Insufficiency and  
Nephritis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. 8 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Benj. S. Hayden, M. D.

Address 1216 N. Caroline St.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

20 UNDERTAKER

DATE OF BURIAL

3/14/22

ADDRESS

502 E. York

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 62242

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62242

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2212 Lehigh Ave. 15 WARD)

## 2-FULL NAME

Robert Ruggold Calder

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

2212 Lehigh Ave.

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

M.W.Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

April 26 - 1909

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

12

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

## 10 NAME OF FATHER

August R. Calder

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

MD

## 12 MAIDEN NAME OF MOTHER

Maude K. Thompson

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

MD

## 14

Informant (Address)

August R. Calder  
2212 Lehigh Ave.

## 15

MAR 12 1922ROBERT H. KRAUTER,Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-10-1922

17

I HEREBY CERTIFY, That I attended deceased from April 22, 1921 to March 11, 1922 that I last saw him alive on March 11, 1922 and that death occurred, on the date stated above, at 9:00 a. m.

The CAUSE OF DEATH\* was as follows:

Rheumatic fever 2 mo.  
acute. Parainfluenza  
myocarditis(duration) yrs. 4 mos. ds.

## CONTRIBUTORY (Secondary)

acute. Endocarditis  
myocarditis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. R. Calder M. D.19 3/14/22 (address) 2757 W. Monaca

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

Rock Hall  
H. W. Carter3/13 1922  
502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



HEALTH DEPARTMENT—CITY OF BALTIMORE **D 62243****D 62243**

## CERTIFICATE OF DEATH.

31

## 1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer Thomas(a) RESIDENCE. No. 236 Bethel st.ST. 3 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 19037 AGE Years Months Days If LESS than 1 day. hrs. or min.  
19

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER August Thomas11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Annie Jones13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown14 Informant Hospital Records  
(Address) M. T. H.15 File MAR 12 1922 ROBERT R. KRAUTER,  
Burial Permit Clerk, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10, 192217 I HEREBY CERTIFY, That I attended deceased from February 15, 1922 to March 10, 1922that I last saw him alive on March 9, 1922and that death occurred, on the date stated above, at 12.50 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
If not at place of death? UnknownDid an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis T.B. in sputum, X-ray(Signed) Francis L. Dabaghi M. D.3-10-22 (Address) Municipal Tbc. Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL Poplar Heights DATE OF BURIAL March 12 192220 UNDERTAKER John W. HendersonADDRESS 1502

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62244

## CERTIFICATE OF DEATH.

D 62244

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *544 Dolphin* ST. *17* WARD)2-FULL NAME *Lydia J. Blake*(a) RESIDENCE. No. *544 Dolphin* ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *40* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Female Colored**Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Peter Blake*

6 DATE OF BIRTH (month, day, and year)

*1847*

7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

*75*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

*ooo*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Mo.*

10 NAME OF FATHER

*Shadrach Nelson*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Mo.*

12 MAIDEN NAME OF MOTHER

*Annie Davis*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Mo.*

14

Informant (Address)

*Annie Earl 544 Dolphin*

15

F

MAR 12 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 9 1922*

I HEREBY CERTIFY, That I attended deceased from

*Mar 2, 1922* to *Mar 9, 1922*that I last saw him alive on *Mar 9, 1922*and that death occurred, on the date stated above, at *4 a.m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Apoplexy**Exhaustion*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical*Signed *Dr. J. B. Hughes* M. D.19 (Address) *1413 B. Hill Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Laurel Lane* *3/12 1922*

20 UNDERTAKER

ADDRESS

*Laurel Lane* *108 B. Hill Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 62245

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 Gold ST., 15 WARD)

2-FULL NAME

(a) RESIDENCE NO. 603 Gold ST., 15 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of Queen Rogers (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE 34 Years 0 Months 0 Days If LESS than 1 day, 0 hrs. or 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Jamaica (State or country) West Indies

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) Jamaica (State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Jamaica (State or country)

14 Informant Queen Rogers (Address) 603 Gold St

15 MAR 12 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 5 1922 to Mar 9 1922, that I last saw her alive on Mar 9 1922, and that death occurred, on the date stated above, at 330 P. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) 5 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) William F. Day M. D.

1922 (Address) 1928 Pa Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Not Buried 3/12 1922  
Samuel T. Ferguson 378 W. Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62246

159-082  
D 62246

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. / ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>Male</i>	4-COLOR OR RACE, <i>colored</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <i>single</i>
6-DATE OF BIRTH, <i>March 10, 1922</i> (Month) (Day) (Year)		
7-AGE, ..... yrs. .... mos. .... ds. If LESS than 1 day, <i>17 hrs. or .... min.</i>		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). <i>none</i> <i>(Infant)</i>		
9-BIRTHPLACE, (State or Country), <i>Balt. Md.</i>		
PARENTS.	10-NAME OF FATHER, <i>Ldney Harmon</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>Md.</i>	
	12-MAIDEN NAME OF MOTHER, <i>Gorgiana Means</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Va.</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ldney Harmon*  
(Address) *933 Angell Ave.*

15-**MAR 12 1922** **ROBERT R. KRAUTER,**  
Filed ..... 191..... Burial Permit: *Cluck*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, <i>March 10, 1922</i> (Month) (Day) (Year)	17- I HEREBY CERTIFY, That I took charge of the remains described above, held an <i>inquest</i> (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said <i>inquest</i> (Inquest, autopsy or inquiry.) and that said deceased came to <i>his</i> death on the day stated above. The CAUSE OF DEATH* was as follows: <i>Infant</i> <i>12 hrs.</i> (Duration) ..... yrs. .... mos. .... ds. CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. .... mos. .... ds. (Signed) <i>J. J. Hennessy</i> M. D. (Coroner.) <i>March 11, 1922</i> (Address) <i>280 Hennessy St.</i>
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place ..... In the ..... of death ..... yrs. .... mos. .... ds. State ..... yrs. .... mos. .... ds. Where was disease contracted, if not at place of death: .....	
Former or usual residence: .....	

19-PLACE OF BURIAL OR REMOVAL, <i>mt auburn</i>	DATE OF BURIAL, <i>Mar 14 1922</i>
20-UNDERTAKER <i>R. G. Gross 1405 Maryland</i>	ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62247

## CERTIFICATE OF DEATH.

31 D 62247

1-PLACE OF DEATH U.S. Veterans Hospital #56

CITY OF BALTIMORE: (No. Ft. McHenry, Md.. ST. 17 WARD)

2-FULL NAME Boyler, Louis

(a) RESIDENCE NO. 425 Myrtle Ave., Baltimore, Md.. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 20 Years Months Days If LESS than 1 day, hrs. or min. -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 086

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer --

9 BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant E. T. Rosenbrock (Address) Registrar

15 File MAR 12 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/11/22 19

17 I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1921, to March 11, 1922, that I last saw him alive on March 11, 1922,

and that death occurred, on the date stated above, at 3.30 A.M.

The CAUSE OF DEATH\* was as follows:

Tuberculosis ~~and~~ pulmonary acute military

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) --- (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of --

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. N. Gordon, M. D.

, 19 (Address) Ft. McHenry, Md..

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

Westmorden Co. Va. May 14, 22

20 UNDERTAKER ADDRESS

A. C. Frost 1405 McElderry

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62248

## CERTIFICATE OF DEATH.

90 D 62248

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1108 S. Binney*)ST. *1* WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Marie Pickert*(a) RESIDENCE No. *1108 S. Binney*  
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos.

ds. How long in U. S., if of foreign birth? *45* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*5a If married, widowed, or divorced ~~husband~~ of (or) WIFE of *Adam Pickert*6 DATE OF BIRTH (month, day, and year) *Jan. 6 - 1891*7 AGE Years *91* Months *2* Days *4* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at home*(b) General nature of industry, business, or establishment in which employed (or employer) *ood*

(c) Name of employer

9 BIRTHPLACE (city or town) *Germany.*  
(State or country)10 NAME OF FATHER *Not known*11 BIRTHPLACE OF FATHER (city or town) *Not known*  
(State or country)12 MAIDEN NAME OF MOTHER *Not known*13 BIRTHPLACE OF MOTHER (city or town) *Not known*  
(State or country)14 Informant *Henrietta Orzech.*  
(Address) *1108 S. Binney*15 *MAR 12 1922* ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 10 1922*17 I HEREBY CERTIFY, That I attended deceased from *Feb 1 1922* to *March 10 1922* that I last saw her alive on *March 10 1922* and that death occurred, on the date stated above, at *1.30 P.* m.

The CAUSE OF DEATH\* was as follows:

*Arterio-sclerosis*(duration) *3* yrs. mos. ds.CONTRIBUTORY (Secondary) *myocarditis*(duration) *1* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *M. J. M. Awoy*, M. D.*3/10/22* (Address) *839 S. Ellwood St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Schwartz's cemetery**Mar 12 1922*

20 UNDERTAKER

ADDRESS

*Zirkler + Zirkler**1739 E. Egan St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

62249

## CERTIFICATE OF DEATH.

90 D 62249

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2625 Fair Ave

ST.:

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Harry Nicoll

## (a) RESIDENCE. No.

2625 Fair Ave

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed,

Divorced (write the word)

Widowed

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Margaret Nicoll

## 6 DATE OF BIRTH (month, day, and year)

Feb. 24-1876

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

46

-

15

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Foreman

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

Columbia Gas Corp.

## 9 BIRTHPLACE (city or town)

(State or country)

Balto., Md.

## 10 NAME OF FATHER

Wm. T. Nicoll

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balto., Md.

## 12 MAIDEN NAME OF MOTHER

Ellen Meads

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto., Md.

## 14

Informant  
(Address)Harry E. Nicoll  
1505 Braddock Ave

## 15

MAR 12 1922

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 11 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

March 1 - 1922, to March 6, 1922,

that I last saw him alive on March 6, 1922,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH\* was as follows:

Valvular Dis. of Heart -

(duration) 1 yrs. - mos. - ds.

CONTRIBUTORY  
(Secondary)

Coronary artery

(duration) yrs. mos. 1 ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. M. B. M. D.

11/3/19 (Address)

125 E. Bldg -

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Mt. Carmel Cemetery

Mar. 14 1922

## 20 UNDERTAKER

Zukler + Zukler

## ADDRESS

1739 E. Eager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62250

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 E University Parkway ST. 17 WARD)

2-FULL NAME

Rebecca W. Katel

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 223 E University Parkway ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs 2 mos 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

Frederick W. Katel

6 DATE OF BIRTH (month, day, and year) Dec. 17<sup>th</sup> 1859

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 62 2 21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

10 NAME OF FATHER Joseph Ware

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

U. S.

12 MAIDEN NAME OF MOTHER Susanna Carroll

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Frederick W. Katel (Address) 223 University Parkway

15 Filed MAR 12 1922 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10<sup>th</sup> 1922

17 I HEREBY CERTIFY, That I attended deceased from

March 5- 1922, to March 10 1922.

that I last saw her alive on March 10 1922

and that death occurred, on the date stated above, at 9:50 P. m.

The CAUSE OF DEATH\* was as follows:

Stroke - Lobar - Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY Cause of action (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinal

(Signed) J. M. B. M. D.

, 19 (Address) 125 E. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore Cemetery

DATE OF BURIAL

Mar 13<sup>th</sup> 1922

20 UNDERTAKER

George Schilling & Sons

ADDRESS

4126 E. Monument



D 62251 HEALTH DEPARTMENT—CITY OF BALTIMORE 001 62251

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 W. 25<sup>th</sup> ST., 12 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Edward Wooden

## (a) RESIDENCE NO.

114 W. 25<sup>th</sup>

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of Sarah E Wooden

6 DATE OF BIRTH (month, day, and year) July 9<sup>th</sup> 1857

7 AGE Years 65 Months 1 Days 1 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman job

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co Md (State or country)

10 NAME OF FATHER Steven Wooden

11 BIRTHPLACE OF FATHER (city or town) Balto Co Md (State or country)

12 MAIDEN NAME OF MOTHER Mary Tash

13 BIRTHPLACE OF MOTHER (city or town) York Pa (State or country)

14 Informant Dr Howard E Wooden (Address) 530 E North ave

15 MAR 12 1922 ROBERT R. KRAUTER, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10<sup>th</sup> 1922I HEREBY CERTIFY, That I attended deceased from 10<sup>th</sup> 1922 that I last saw him alive on March 10<sup>th</sup> 1922, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH\* was as follows:

Paralysis of the brain (duration) 7 wks  
Contributory Cause of Death: Cerebral Haemorrhage (duration) indef.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Richardson M. D.

(Address) 117 A. 23 St

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park Cemetery

20 UNDERTAKER

George Schilling &amp; Sons

DATE OF BURIAL

Mar 14<sup>th</sup> 1922

ADDRESS

1126 E Monument St

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62252

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. 68 Irving St. West Springfield, Mass.

(Usual place of abode)

ST.: 7 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred — 7 — mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

6 If married, widowed, or divorced

HUSBAND or WIFE of Edward Mellen (father)

6 DATE OF BIRTH (month, day, and year) Jan. 25, 1916

7 AGE

6

Years

Months

1

Days

15

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mass.

10 NAME OF FATHER

Edward Mellen

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

Martha Hloyte

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

MAR 12 1922

ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 17, 1922, to March 12, 1922

that I last saw him alive on March 12, 1922

and that death occurred, on the date stated above, at 7:40 a. m.

The CAUSE OF DEATH\* was as follows:

Brain Tumor

Cerebros

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter E. Dandy, M. D.

(Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Springfield, Mass

Mar 12 1922

20 UNDERTAKER

ADDRESS

Geo M. Quinn &amp; Son

811 N. Wolfe St.

is very important. See instructions on back of certificate. Exact statement of OCCUPATION

D 62253

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62253

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4 S. 5th. St. Brooklyn, St. 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

William Essex.  
(Residence in Baltimore: No. 24 S. 1st. St. Brooklyn, St. 50 yrs. 50 mos. 50 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male. 4-COLOR OR RACE. White. 5-Single, Married, Widowed, or Divorced. Married (Write the word.)

6-DATE OF BIRTH. December 19th. 1866. 1. (Month) (Day) (Year)

7-AGE. 55 yrs. 2 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Foreman. (b) General nature of industry, business, or establishment in which employed (or employer). Fertilizing Co.

9-BIRTHPLACE, (State or Country). Virginia.

10-NAME OF FATHER. George W. Essex.

11-BIRTHPLACE OF FATHER, (State or Country). Virginia.

12-MAIDEN NAME OF MOTHER. Virginia Jones.

13-BIRTHPLACE OF MOTHER, (State or Country). Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barbara F. Essex. (wife)

(Address) 24 S. 1st. St. Brooklyn.

MAR 12 1922

ROBERT R. KRAUTER  
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 9th. 1922. 1922 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above. (Inquest, au- topsy or inquiry.)

The CAUSE OF DEATH\* was as follows: Accidentally suffocated and burns about the body. Turning over of an oil stove.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) yrs. mos. ds.

(Signed) E. R. Reinhardt M. D. (Coroner.)

192 (Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). In the

At place of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Cedar Hill Cemetery Mar 13 1922

20-UNDERTAKER. ADDRESS

John F. Denny 715 Light St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62254

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1508 Poplar Grove. ST.: 16 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Reah Smively(a) RESIDENCE. NO. 1508 Poplar Grove.  
(Usual place of abode)

ST.: \_\_\_\_\_ WARD. \_\_\_\_\_

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Married.

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

Hubert Biser Smively6 DATE OF BIRTH (month, day, and year) OCT 17-18867 AGE Years 35 Months 4 Days 22 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shirt maker.(b) General nature of industry, business, or establishment in which employed (or employer) Shirt waist factory(c) Name of employer unknown.9 BIRTHPLACE (city or town) Gilpintown, Ind.  
(State or country)10 NAME OF FATHER — Brashears.11 BIRTHPLACE OF FATHER (city or town) —  
(State or country) Maryland.12 MAIDEN NAME OF MOTHER unknown13 BIRTHPLACE OF MOTHER (city or town) —  
(State or country) Maryland.14 Informant Hubert Biser Smively  
(Address) 1508 Poplar Grove St

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 192217 I HEREBY CERTIFY, That I attended deceased from 3-8-22, 1922, to 3-11-22, 1922.that I last saw her alive on 3-11-22, 1922.and that death occurred, on the date stated above, at 6:08 a. m.

The CAUSE OF DEATH\* was as follows:

Bronchial Pneumonia(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 6 ds.

CONTRIBUTORY (Secondary)

Influenza(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 14 ds.18 Where was disease contracted if not at place of death? unknownDid an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? auscultation & palpation(Signed) Chester Poland, M. D.3-11, 1922 (Address) 2532 Edmondson Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Freederville Md3-13 1922

20 UNDERTAKER

ADDRESS 517 NH. BrannenSchneider

MAR 12 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62255

## CERTIFICATE OF DEATH.

D 62255

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.: *4* WARD: *4*)

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Frederick F. Abell*(a) RESIDENCE. NO. *Albenton, Md* ST.: .... WARD: *Albenton Md*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *4* yrs. .... mos. .... ds.

How long in U. S., if of foreign birth? yrs. .... mos. .... ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Widowed*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *—*6 DATE OF BIRTH (month, day, and year) *Apr. 25, 1864*

7 AGE

Years

Months

Days

If LESS than 1 day, .... hrs. or min. *57 10 14*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Engineer*(b) General nature of industry, business, or establishment in which employed (or employer) *030*

(c) Name of employer

9 BIRTHPLACE (city or town) *Albenton, Va* (State or country)10 NAME OF FATHER *George F. Abell*11 BIRTHPLACE OF FATHER (city or town) *Va* (State or country)12 MAIDEN NAME OF MOTHER *Jane Berry*13 BIRTHPLACE OF MOTHER (city or town) *Va* (State or country)

14

Informant (Address) *Mercy Hospital Records*

MAR 12 1922

ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 11, 1922*

17

I HEREBY CERTIFY, That I attended deceased from *March 7, 1922* to *March 11, 1922*.that I last saw him alive on *March 11, 1922*.and that death occurred, on the date stated above, at *4:20 a. m.*

The CAUSE OF DEATH\* was as follows:

*Sacro-Rectal abscess.*

(duration)

yrs.

mos.

ds. *14*CONTRIBUTORY (Secondary) *Uremia*

(duration)

yrs.

mos.

ds. *2*18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *Yes* Date *3/7/22*Was there an autopsy? *Yes*What test confirmed diagnosis? *Symptoms*(Signed) *John H. Berry, M. D.*, 19 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL *St. John's Church*DATE OF BURIAL *Mar. 14, 1922*20 UNDERTAKER *Easton Sons*ADDRESS *Ellicott City*

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62256

## CERTIFICATE OF DEATH.

43 D 62256

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 542 W Lee ST., 27 WARD)

2-FULL NAME Rose T. Schneider

(a) RESIDENCE NO. 542 W Lee ST., 27 WARD

(Usual place of abode)

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Schneider

6 DATE OF BIRTH (month, day, and year) Jan 30 - 1881

7 AGE Years 41 Months 1 Days 10 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER John Mack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't know

14 Informant Henry Schneider

15 MAR 12 1922 ROBERT R. KRAUTER, Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1st 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1st 1922 to March 1st 1922

that I last saw him alive on March 2nd 1922

and that death occurred, on the date stated above, at 3:45 m.

The CAUSE OF DEATH\* was as follows:

Myocardial Infarction

(duration) one yrs. one mos. one ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) one yrs. one mos. one ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin S. Smith, M. D.

, 19 (Address) 101 E. Bay St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Greenwood Cem.

Mar 13 1922

20 UNDERTAKER

ADDRESS

F.A. Isaac & Son

7037 Penn St

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1900 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62257

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Child Hosp WARD)

### 2-FULL NAME

Douglas Anderson

(a) RESIDENCE. No. Nursery & Child Hosp WARD.

(Usual place of abode) 58. East Schroeder & Frank (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 26 1921

7 AGE Years Months Days If LESS than 1 day, hrs. or min. — 11 13

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md. (State or country)

10 NAME OF FATHER Roy Anderson

11 BIRTHPLACE OF FATHER (city or town) Crisfield Md (State or country)

12 MAIDEN NAME OF MOTHER Tresa Breen

13 BIRTHPLACE OF MOTHER (city or town) Laurel Md (State or country)

14 Informant Miss George A. Hutton (Address) 2 & B. Hospital

15 **MAR 18 1922** ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11<sup>th</sup> 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 1<sup>st</sup> 1922, to Mar 11, 1922, that I last saw him alive on Mar 11, 1922, and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

La Grippe (duration) yrs. mos. 10 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Paul H. Brinkley M. D.

, 19 (Address) 2022 E. Pratt St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Loudon Park

March 13, 1922

20 UNDERTAKER

ADDRESS

George J. Smith

1000 W. Fayette St.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62258 HEALTH DEPARTMENT—CITY OF BALTIMORE  
CERTIFICATE OF DEATH.  
31<sup>st</sup> D 62258  
Registered No. C.....

1-PLACE OF DEATH *Franklin Square Hospital* 7 Ward  
City of BALTIMORE: (No. *John W. Langridge*)  
2-FULL NAME  
(Residence in Baltimore: No. *929 N. Broadway* St.; yrs. .... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX, *Male* 4-COLOR OR RACE, *White* 5-STATUS, *Married*  
6-DATE OF BIRTH, *Jan 30*, 1868.  
7-AGE, *54* yrs. .... mos. .... ds. If LESS than 1 day, .... hrs. or .... min.?  
8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *None*  
(b) General nature of industry, business, or establishment in which employed (or employer), *None*  
9-BIRTHPLACE, (State or Country), *Maryland*  
10-NAME OF FATHER, *Unknown*  
11-BIRTHPLACE OF FATHER, (State or Country), *Unknown*  
12-MAIDEN NAME OF MOTHER, *Unknown*  
13-BIRTHPLACE OF MOTHER, (State or Country), *Unknown*  
14-THE ABOVE I TRIE TO THE BEST OF MY KNOWLEDGE.  
(Informant) *Mrs. Wm Collins*  
(Address) *929 N. Broadway*  
15- *MAR 12 1922* ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *March 10*, 1922.  
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest*, (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said *Inquest*, find that said deceased came to *his* death (Inquest, autopsy or Inquiry.) on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
*Pulmonary Tuberculosis*  
Duration) *1* yrs. .... mos. .... ds.  
CONTRIBUTORY (Secondary) *Pulmonary Hemorrhage*  
(Signed) *James W. Kenton* M. D. (Coroner.)  
*Mar 12 1922* (Address) *701 E. Chase St.*  
\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.  
18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents.)  
At place of death, *Franklin Square Hospital*, In the State, .... yrs. .... mos. .... ds.  
Where was disease contracted, if not at place of death?  
*I don't know*  
Former or usual residence *929 N. Broadway*  
19-PLACE OF BURIAL OR REMOVAL, *Patton Cemetery* DATE OF BURIAL, *3/13*, 1922  
20-UNDERTAKER, *William Cook* ADDRESS, *501 E. North*



Every item of information should be stated EXACTLY. PHYSICIANS should state statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

ys.

mos.

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White

Married

5a If married, widowed, or divorced

HUSBAND

(or) WIFE of

Mr. Edward S. Cravens.

6 DATE OF BIRTH (month, day, and year)

Aug. 2, 1888

7 AGE

Years

Months

Days

If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.

33

8

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ohio

10 NAME OF FATHER

Edward Bass

11 BIRTHPLACE OF FATHER (city or town) (State or country)

New York

12 MAIDEN NAME OF MOTHER

Ann Bass

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

New York

14

Informant (Address)

JOHNS HOPKINS HOSPITAL, Records

15

MAR 13 1922

ROBERT R. KRAUTER, Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 12, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 21, 1922, to March 12, 1922

that I last saw her alive on March 12, 1922

and that death occurred, on the date stated above, at 1:05 A. M.

The CAUSE OF DEATH\* was as follows:

Miliary Tuberculosis

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

CONTRIBUTORY (Secondary)

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 2-24-22

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Julian S. Hact, M. D.

, 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Huntington W. Va. Mar. 12 1922

20 UNDERTAKER

ADDRESS

William E. Schaeffer 1816 Monument

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Lungs involved*  
*General tuberculosis*

Spec.—6-9-19—H. P. Co.—1000 Bks.  
D 62260  
HEALTH DEPARTMENT—CITY OF BALTIMORE  
CERTIFICATE OF DEATH.  
1-PLACE OF DEATH  
CITY OF BALTIMORE: (No. 002 Woodbourne Ave ST. 9 WARD)  
2-FULL NAME Elizabeth McJannity  
(a) RESIDENCE. NO. 002 Woodbourne ST. WARD.  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.  
PERSONAL AND STATISTICAL PARTICULARS  
3 SEX F 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced (write the word) Single  
5a If married, widowed, or divorced HUSBAND of (or) WIFE of —  
6 DATE OF BIRTH (month, day, and year) Unknown  
7 AGE Years Months Days If LESS than 1 day, hrs. or min. 40  
8 OCCUPATION OF DECEASED  
(a) Trade, profession or particular kind of work Home opp  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer  
9 BIRTHPLACE (city or town) (State or country) Baltimore Md  
10 NAME OF FATHER Robert McJannity  
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland  
12 MAIDEN NAME OF MOTHER Ellen Williams  
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland  
14 Informant Bernard McJannity (Address) Woodbourne Ave  
15 MAR 13 1922 ROBERT K. KRAUTER, Registrar  
Burial Permit Clerk.  
MEDICAL CERTIFICATE OF DEATH  
16 DATE OF DEATH (month, day, and year) March 10 1922  
17 I HEREBY CERTIFY, That I attended deceased from June 1917, to March 4, 1922, that I last saw him alive on March 4 1922 and that death occurred, on the date stated above, at 5:30 p.m.  
The CAUSE OF DEATH\* was as follows:  
Pulmonary Tuberculosis  
(duration) 5 yrs. mos. ds.  
CONTRIBUTORY Cordiae ostium (Secondary) (duration) yrs. mos. 10 ds.  
18 Where was disease contracted - 520 4 Glenview St  
If not at place of death?  
Did an operation precede death? — Date of  
Was there an autopsy?  
What test confirmed diagnosis? Clinical  
(Signed) Edward H. Henshaw, M. D.  
3/12 1922 Address 24 W Fullan St  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)  
19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL  
New Cathedral 3-13-1922  
20 UNDERTAKER ADDRESS 517 N  
H C Branning, Son Schroeder St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 62260

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 002 Woodbourne Ave ST. 9 WARD)

2-FULL NAME

Elizabeth McJannity

(a) RESIDENCE. NO.

002 Woodbourne ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

40

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home opp

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Robert McJannity

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Ellen Williams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant (Address)

Bernard McJannity Woodbourne Ave

15

MAR 13 1922

ROBERT K. KRAUTER, Registrar

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

9

D 62260

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1922

17

I HEREBY CERTIFY, That I attended deceased from

June 1917, to March 4, 1922,

that I last saw him alive on March 4 1922

and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cordiae ostium

(duration) yrs. mos. 10 ds.

18 Where was disease contracted - 520 4 Glenview St  
If not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

Clinical

(Signed) Edward H. Henshaw, M. D.

3/12 1922 Address 24 W Fullan St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral

3-13-1922

20 UNDERTAKER

ADDRESS 517 N

H C Branning, Son

Schroeder St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

62261

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62261

1-PLACE OF DEATH

City of BALTIMORE: (No. 931 E. Baltimore St. Ward 3)

2-FULL NAME

(Residence in Baltimore: No. 931 E. Baltimore St. St.; yrs. unkn mos. unkn ds.)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-Marital Status

Married  
Widowed  
or Divorced  
(Write the word.)

6-DATE OF BIRTH

March 15 1873  
(Month) (Day) (Year)

7-AGE

48 yrs. unkn mos. unkn ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Comet Player 1886

9-BIRTHPLACE  
(State or Country).

Italy

10-NAME OF FATHER

Angelo Mullinoy

11-BIRTHPLACE OF FATHER  
(State or Country).

Italy

12-MAIDEN NAME OF MOTHER

Maria Conarango

13-BIRTHPLACE OF MOTHER  
(State or Country).

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. M. Mullinoy

(Address)

931 E. Baltimore St.

15-

MAR 13 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

April 11 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, and that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chr. Nephritis

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Duration) yrs. mos. ds.

(Signed) M. D. M. D.

(Coroner)

Adm. 1922 (Address) 587 Ave.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place 744 minutes In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Redeemer Center

March 13, 1922

20-UNDERTAKER

ADDRESS

George J. Ruth

1735 Hayford Ave.



D 62262

HEALTH DEPARTMENT—CITY OF BALTIMORE

163 D 62262

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 921 4th medium 10th WARD)

## 2-FULL NAME

Baby Crook.

(Residence in Baltimore: No. 921 4th medium

## REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, col 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Bay (Write the word.)

6-DATE OF BIRTH, Jan. 22, 1922 (Month) (Day) (Year)

7-AGE, If LESS than 1 day, yrs. mos. da. .... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Baby, 000  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.  
(State or Country), Balto

10-NAME OF FATHER, William Crook  
11-BIRTHPLACE OF FATHER (State or Country), Balto  
12-MAIDEN NAME OF MOTHER, Hamm Harris  
13-BIRTHPLACE OF MOTHER (State or Country), Balto

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15 MAR 13 1922 ROBERT R. KRAUTER, Burial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

Mar 11, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held as (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lack of car (Duration) .... yrs. .... mos. .... da.

CONTRIBUTORY  
(Secondary)

(Signed) J. H. Jones, D. (Coroner.)  
3-12, 1922 (Address) 4th medium

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? ....

## Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Laurel Cem. Mar 13, 1922

## 20-UNDERTAKER

## ADDRESS

Chris. N. Johnson 416 N. Calver

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62263

HEALTH DEPARTMENT—CITY OF BALTIMORE

62263

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 720 Rickett Court. St. 22 Ward)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie Smith. (C).

(Residence in Baltimore: No. 720 Rickett Court. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female. 4-COLOR OR RACE, Colored. 5-Single, Married, Widowed, or Divorced, (Write the word.) Married.

6-DATE OF BIRTH, Do not know. 1. (Month) (Day) (Year)

7-AGE, 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None. (b) General nature of industry, business, or establishment in which employed (or employer), 037

9-BIRTHPLACE, (State or Country), Virginia.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER, (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lemuel Smith. (C) (husband)

(Address) 720 Rickett Court.

15- MAR 13 1922 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 10th, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above. (Inquest, autopsy or inquiry.)

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Reinhardt M. D. (Coroner.)

March 11 1922. (Address) 1014 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Mt. Auburn Mar 13 1922

20-UNDERTAKER, ADDRESS 142

John H. Treadwell

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

*Jennie Chambers*

Spec. 6-9-19-H. P. Co.-1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

**D 62264** 179 **D 62264**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *516 W. Cross* ST. *21* WARD)

2-FULL NAME *Jennie Chambers*

(a) RESIDENCE, NO. *516 W. Cross* ST., WARD. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS					MEDICAL CERTIFICATE OF DEATH	
3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)			16 DATE OF DEATH (month, day, and year) <i>March 10 19 22</i>	
<i>Female</i>	<i>Colored</i>	<i>Widowed</i>			17 I HEREBY CERTIFY, That I attended deceased from <i>Feb 10</i> , 19 <i>22</i> , to <i>March 10</i> , 19 <i>22</i> , that I last saw her alive on <i>March 10</i> , 19 <i>22</i> , and that death occurred, on the date stated above, at <i>7:30 P.</i> m. The CAUSE OF DEATH* was as follows: <i>Bright's Disease</i>	
6 DATE OF BIRTH (month, day, and year) <i>June 1860</i>	7 AGE Years Months Days	If LESS than 1 day, hrs. or min.		CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. <i>As above</i>		
<i>62</i>				18 Where was disease contracted <i>From</i> if not at place of death? Did an operation precede death? <i>NO</i> Date of Was there an autopsy? <i>NO</i> What test confirmed diagnosis? <i>Characteristic of Bright's Disease</i> (Signed) <i>C. H. Jones</i> M. D. 714 S. Pearl Street		
8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work <i>at home</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>07</i> (c) Name of employer					*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)	
9 BIRTHPLACE (city or town) (State or country) <i>Balt.</i>					19 PLACE OF BURIAL, CREMATION OR REMOVAL <i>Mt. Auburn</i> DATE OF BURI <i>March 14</i>	
10 NAME OF FATHER <i>James Smith</i>					20 UNDERTAKER <i>John H. Trade</i> ADDRESS <i>unrecd</i>	
11 BIRTHPLACE OF FATHER (city or town) (State or country) <i>Md.</i>						
12 MAIDEN NAME OF MOTHER <i>Harriet Smith</i>						
13 BIRTHPLACE OF MOTHER (city or town) (State or country) <i>Md.</i>						
14 Informant <i>Violet Wright</i> (Address) <i>576 W. Cross St.</i>						
15 Filed <i>MAR 13 1922</i> Registrar						

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62265

## CERTIFICATE OF DEATH.

X 90 D 62265

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1533 E. Madison ST.

WARD 7

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. 1533 E. Madison ST.

WARD. New York

(Usual place of abode)

(If nonresident give city, town and State)

Length of residence in city or town where death occurred

yrs. 2 mos.

ds. How long in U. S., if of foreign birth?

yrs. 2 mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAR 13 1922

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 21, 21 to March 10, 1922

that I last saw him alive on March 9, 1922

and that death occurred, on the date stated above, at 7:10 a. m.

The CAUSE OF DEATH\* was as follows:

Mitral regurgitation over

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute nephritis (duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? New York

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jacob Kobice

3/10/22 (Address) 512 Monument St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Samuel Bern 3/13/22

20 UNDERTAKER ADDRESS

Jas. M. Skinner 1626 C. Street

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No other abnormal  
condition. Not  
tuberculosis*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 62266

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44

D 62266

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3729 Falls Road | 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Lee

(a) RESIDENCE. No. 3729 Falls Road WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Lee

6 DATE OF BIRTH (month, day, and year) Sept 11 1861

7 AGE 60 Years 6 Months 1 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ind (State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mie L Shary (Address) 3729 Falls Road

15 Filed MAR 13 1922 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1922, to March 12, 1922, that I last saw her alive on Mar 12, 1922.

and that death occurred, on the date stated above, at 1036 P.M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Stomach

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Diagnosed by pathologist

(Signed) C. J. [Signature], M. D.

12 22, 19 (Address) 3701 [Address]

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St Marys Hampden March 15 1922

20 UNDERTAKER ADDRESS

Cohenoweth Son Chestnut

STATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62267

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2733)

ST. WARD

2-FULL NAME

Eli. J. Jones

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2733)

St. yrs. mos. (ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 4-COLOR OR RACE, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, 6-DATE OF BIRTH, 7-AGE, 8-OCCUPATION:

9-BIRTHPLACE, 10-NAME OF FATHER, 11-BIRTHPLACE OF FATHER, 12-MAIDEN NAME OF MOTHER, 13-BIRTHPLACE OF MOTHER

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Sarah Jones (Address) 2733

15-ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 17-I HEREBY CERTIFY, That I took charge of the remains described above, held a

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, Where was disease contracted, if not at place of death?

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, 20-UNDERTAKER

CONTRIBUTORY, (Signed) J. H. Hannon, D. (Coroner.)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, 20-UNDERTAKER

Bulls Ben March 13 1922

Chenoweth & Chestnut St

MAR 13 1922

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 62268 HEALTH DEPARTMENT—CITY OF BALTIMORE  
CERTIFICATE OF DEATH. H 62268

1-PLACE OF DEATH  
CITY OF BALTIMORE: (No. 705 Bunnecke ave ST. 3 WARD)  
2-FULL NAME Annie A. Meeker  
(a) RESIDENCE. No. 705 Bunnecke ave ST. 3 WARD.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)  
Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>F</u>	4 COLOR OR RACE <u>W</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Married</u>
5a If married, widowed, or divorced HUSBAND of (or) WIFE of <u>William F. Meeker</u>		
6 DATE OF BIRTH (month, day, and year) <u>June 8 1866</u>		
7 AGE Years <u>53</u>	Months <u>8</u>	Days <u>4</u> If LESS than 1 day. hrs. or min.
8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work <u>House wife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>037</u> (c) Name of employer		
9 BIRTHPLACE (city or town) (State or country) <u>MD</u>		
10 NAME OF FATHER <u>James Slater</u>		
11 BIRTHPLACE OF FATHER (city or town) (State or country) <u>MD</u>		
12 MAIDEN NAME OF MOTHER <u>Sarah Streater</u>		
13 BIRTHPLACE OF MOTHER (city or town) (State or country) <u>MD</u>		

14 Informant Ann F. Meeker  
(Address) 705 Bunnecke Ave  
15 MAR 13 1922 ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 15 1921, to March 12 1922, that I last saw her alive on March 12 1922, and that death occurred, on the date stated above, at 2:15 P.

The CAUSE OF DEATH\* was as follows:  
Carcinoma of RT Breast.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY Breast metastases  
(Secondary) (duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? yes Date of April 1-22

Was there an autopsy? no

What test confirmed diagnosis? Exam

(Signed) W. Smith M. D.  
March 12-22 (Address) 3429 Chestnut St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden DATE OF BURIAL March 14 1922  
20 UNDERTAKER Chenoweth Son ADDRESS Chestnut Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

Boy View Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 13 WARD)

2-FULL NAME

John Bell

(a) RESIDENCE. (No.

3500 Poole

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or, WIFE of)

Unknown

6 DATE OF BIRTH (month, day, and year)

March 19, 1850

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Railroad Employee

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Unknown

14

Informant  
(Address)Boy View Hospital  
Baltimore, Md.

15

Filed

19

MAR 13 1922

ROBERT R. KRAUTER  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 11, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 21, 1922 to March 11, 1922

that I last saw him alive on March 11, 1922

and that death occurred, on the date stated above, at 12:30 P. M.

The CAUSE OF DEATH\* was as follows:

Acute Myocardial Clotting

CONTRIBUTORY

(Secondary)

Coronary Hypertrophy

18 Where was disease contracted  
if not at place of death?

Unknown

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical findings

(Signed)

H. J. Grooms, M. D.

3/12/22

Address Boy View Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Annapolis Co  
Friendship Cem.

March 14, 1922

20 UNDERTAKER

ADDRESS

Chenoweth &amp; Son Chestnut St.

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62270

CERTIFICATE OF DEATH.

101-001  
D 62270  
Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 724 Grindall Court. St. 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
--- 2 --- 24 .

2-FULL NAME

Elna May (C).

(Residence in Baltimore: No. 724 Grindall Ct. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female. 4-COLOR OR RACE, Colored. 5-Single, Married, Widowed, or Divorced, Single (Write the word.)

6-DATE OF BIRTH, December 14th, 1921. (Month) (Day) (Year)

7-AGE, --- yrs. 2 mos. 24 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None. (b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS. 10-NAME OF FATHER, Augustus May (C). 11-BIRTHPLACE OF FATHER, (State or Country), Baltimore Md. 12-MAIDEN NAME OF MOTHER, Lena Williams. (C). 13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Lena May. (C) (mother). (Address) 724 Grindall Ct.

15. MAR 13 1922 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 10th, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That, I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above. The CAUSE OF DEATH\* was as follows:  
Lobar Pneumonia.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) M. D. (Coroner) March 11 1922 (Address) 1017 Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn 3/13/22 DATE OF BURIAL.

20-UNDERTAKER, Robt. L. Parkman ADDRESS 679 E. Fel St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62271

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

ST.

WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

ST.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

6 yrs.

mos.

ds.

How long in U. S. If of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, .... hrs.  
or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant

(Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from

Feb 27, 1922, to Mar 10, 1922,  
that I last saw him alive on Mar 10, 1922,

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? ho Date of

Was there an autopsy? ho

What test confirmed diagnosis?

(Signed) Jacob Fisher, M. D.

3/11, 1922 (Address) 1823 N. Trust St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL.

ST. 16 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Samuel Gover

## (a) RESIDENCE. No.

1012 Appleton

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 16 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

May 19-1921

## 7 AGE

Years

Months

Days

If LESS than  
1 day, \_\_\_\_ hrs.  
or \_\_\_\_ min.

9 20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Child

800

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore  
Md.

## 10 NAME OF FATHER

Samuel Gover

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Baltimore  
Md.

## 12 MAIDEN NAME OF MOTHER

Lillian Freese

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Baltimore  
Md.

## 14

Informant  
(Address)

JOHNS HOPKINS HOSPITAL

## 15

FILE

MAY 13 1922

ROBERT H. KRAUTER

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 11-1922

## 17

I HEREBY CERTIFY, That I attended deceased from

March 11, 1922, to March 15, 1922

that I last saw him alive on March 11, 1922

and that death occurred, on the date stated above, at 9:20 a.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia, lobar

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. 7 ds.

CONTRIBUTORY  
(Secondary)

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

## 18 Where was disease contracted

If not at place of death? 1012 Appleton St Baltimore

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. B. Gay, M. D.

19 (Address) Johns Hopkins Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Baltimore

May 13, 1922

## 20 UNDERTAKER

## ADDRESS

Chas. J. Brown

1724 Perry



D 62273

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 D 62273

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1138 Columbia Ave.* ST. *21* WARD)

## 2-FULL NAME

*Mary E. Fitchett*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE. NO.

*1138 Columbia Ave.*

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Female**White**Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Feb 9 1878*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*44**1**2*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*State Nurse*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balt.*

10 NAME OF FATHER

*Michael Cunningham*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ireland*

12 MAIDEN NAME OF MOTHER

*Mary Murphy*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ireland*

14

Informant (Address)

*Daniel Fitchett 1138 Columbia Ave.*

15

MAR 13 1922

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*March 11 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*February 8, 1922, to March 11, 1922.*that I last saw her alive on *March 8, 1922.*and that death occurred, on the date stated above, at *8:30 A. M.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Uterus*(duration) yrs. *9* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. *2* mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

12, 1922 (Address)

*J. M. Deloitt M. D. 2800 Garrison Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Neer Cathedral**Mar 14 1922*

20 UNDERTAKER

ADDRESS

*Wm. J. Fields 1200 W. Lombard*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62274

62274

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Hammond Bldg.

REGISTERED NO. C

CITY OF BALTIMORE: (No.

2724 N. Charles

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mrs. Mary Louise Bruce

(Residence in Baltimore: No.

212 Vincent Ave

St. 21 yrs. mos. ds)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

Married

6-DATE OF BIRTH.

Aug 21, 1875

7-AGE.

46 yrs. 6 mos. 18 ds.

If LESS than 1 day,  
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular  
kind of work.  
(b) General nature of industry, business, or establishment in which  
employed (or employer).

Home 037

9-BIRTHPLACE,  
(State or Country),Cumberland  
Md.10-NAME OF  
FATHER,

Henry Mason

11-BIRTHPLACE  
OF FATHER  
(State or Country),

Pa

12-MAIDEN NAME  
OF MOTHER

Martha A. Hay

13-BIRTHPLACE  
OF MOTHER  
(State or Country),

Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

M. W. W. Bruce

(Address)

212 Vincent Ave

15-

Hamilton

R 131922

ROBERT R. KRAUTER,

Burial Permit Clerk.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March

11, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from  
March 1 1922, to March 11 1922,  
that I saw her alive on March 11 1922,  
and that death occurred, on the date stated above, at 10:55 m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Omentum  
Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Vernon H. Coudon M. D.

191... (Address) 750 N. North Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,  
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS):

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? At home

Former or usual residence 212 Vincent Ave

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Roudon Park Co. Mar. 1, 1922

20-UNDERTAKER ADDRESS

Wm. J. Pickens North Pa

Physicians should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D62275

HEALTH DEPARTMENT—CITY OF BALTIMORE

D62275

168

CERTIFICATE OF DEATH.

1-PLACE OF DEATH  
CITY OF BALTIMORE (No. *2618 N. Charles* ST. *17* WARD)  
2-FULL NAME *Mina Weilbacher*  
(Residence in Baltimore: No. *2618 N. Charles*)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *Life* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*  
4-COLOR OR RACE, *White*  
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*  
(Write the word.)  
6-DATE OF BIRTH, *Dec 14, 1866*  
(Month) (Day) (Year)  
7-AGE, *55* yrs. *2* mos. *26* ds.  
If LESS than 1 day, ... hrs. or ... min.:  
8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *at home*  
(b) General nature of industry, business, or establishment in which employed (or employer) *ooo*  
9-BIRTHPLACE, (State or Country), *Baltimore*  
10-NAME OF FATHER, *Paul Weilbacher*  
11-BIRTHPLACE OF FATHER (State or Country), *Germany*  
12-MAIDEN NAME OF MOTHER, *Caroline Sieger*  
13-BIRTHPLACE OF MOTHER (State or Country), *Balto Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Clara Wittenbrock*  
(Address) *2618 N Charles*

15-

Filed *MAR 13 1922* ROBERT R. KRAUTER

Registrar.  
Burial Permit Check.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *March 10, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an  
(Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said  
(Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

*Myocardial Infarction*  
*Supine*  
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *J. H. Morrison* M. D.  
(Coroner)  
(Address) *3632 Bolton*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the  
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*Linden Park* *Mar 13 1922*

20-UNDERTAKER

ADDRESS

*Mr. Mitchell 12011 Fayette St*

D 62276

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62276

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

Charles St 32<sup>nd</sup>

ST. 12 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Mary Park Kelly

## (a) RESIDENCE NO.

Allston Apartment

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

61 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Andrew J. Kelly

6 DATE OF BIRTH (month, day, and year)

Sep 16, 1860

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

61

5

25

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

William S Redgrave

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Catherine L. Park

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Phila Pa

14

Informant (Address)

Andrew J. Kelly Charles St 32<sup>nd</sup> St

15

MAR 13 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 1, 1922, to March 11, 1922,

that I last saw her alive on March 11, 1922,

and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH\* was as follows:

Coronary Thrombosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

General arteriosclerosis

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? yrs Date of Feb 1 1921

Was there an autopsy?

no

What test confirmed diagnosis? Clinical &amp; Geriatric

(Signed) W. H. Regan, M. D.

19 (Address) 805 Park Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Green Mount Mch 13 1922

20 UNDERTAKER

ADDRESS

John Mitchell 1201 W. Fayette St



D 62277 HEALTH DEPARTMENT—CITY OF BALTIMORE  
CERTIFICATE OF DEATH.

31 D 62277

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 2 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ignace Grundski(a) RESIDENCE. No. 725 Bond st.ST. 2 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.ds. How long in U. S., If of foreign birth Unknown mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 18647 AGE Years 58 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town) (State or country)

Poland10 NAME OF FATHER James Grundski

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown14 Informant Hospital Records  
(Address) M.T.H.

15

MAR 13 1922ROBERT H. KAUTER  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12, 192217 I HEREBY CERTIFY, That I attended deceased from February 14, 1922, to March 12, 1922.that I last saw him alive on March 12, 1922.and that death occurred, on the date stated above, at 5.35 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(duration) Unknown yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Unknown  
if not at place of death?Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis T.B. in sputum, X-ray(Signed) Francis P. Badaglidze3-12-22, 19 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Rosary March 15 1922

20 UNDERTAKER

ADDRESS

John M. Weber, 1803 Bank

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 62278

D 62278

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2017 Seneca ST., 14 WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

26 yrs.

mos.

ds.

How long in U. S., if of foreign birth

WARD

(If non-resident give city or town and State)

26 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 45 Years 4 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant (Address)

## 15

MAR 13 1922

ROBERT H. KRAUTER, Registrar

Burial Permit

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar, 12 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 10, 1922 to Mar 12, 1922, that I last saw him alive on March 10, 1922, and that death occurred, on the date stated above, at 5:59 m.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis

CONTRIBUTORY (Secondary)

(duration) 1 yrs. - mos. - ds.

(duration) 1 yrs. - mos. - ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Wasserman et al.

(Signed) Dan Franklin, M. D.

3/12, 1922 (Address) 1224 W. See St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

19a PLACE OF BURIAL, CREMATION OR RE- Burial

19b UNDERTAKER

19c ADDRESS

## DATE OF BURIAL

3/13 1922

19d ADDRESS

1224 W. See St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 Karamaugh ST. 15 WARD)2-FULL NAME Clarence H. Spicer(a) RESIDENCE. No. 1819 Karamaugh ST. 15 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 2 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Caucasoid 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Spicer6 DATE OF BIRTH (month, day, and year) Dec. 13, 18717 AGE Years 50 Months 2 Days 26 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Latour

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer American Brake Co.9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)10 NAME OF FATHER Henry A. Spicer11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)12 MAIDEN NAME OF MOTHER Annie Mills13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)14 Informant Elizabeth Spicer(Address) 1819 Karamaugh15 F MAR 13 1922 ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11, 192217 I HEREBY CERTIFY, That I attended deceased from Jan. 3, 1922 to March 11, 1922 that I last saw him alive on March 11, 1922and that death occurred, on the date stated above, at 1:30 P. m.The CAUSE OF DEATH\* was as follows: Chronic Interstitial Nephritis(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Eden urine etc.(Signed) John D. Quinn, M. D.(Address) 1507 N. Fulton Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

UNDERTAKER James D. WrightADDRESS 364 Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 62280

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

57 D 62280

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1333 S. Charles St. ST. 23 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Kelly

(a) RESIDENCE. No. 1333 S. Charles St. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 10 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced  
 HUSBAND of  
 (or) WIFE of William R. Kelly

6 DATE OF BIRTH (month, day, and year) May 5 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	10	5	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.  
(State or country)

10 NAME OF FATHER John Stahle

11 BIRTHPLACE OF FATHER (city or town) Germany  
(State or country)

12 MAIDEN NAME OF MOTHER Katharine Sharp

13 BIRTHPLACE OF MOTHER (city or town) Germany  
(State or country)14 Informant William R. Kelly  
(Address) 1333 S. Charles St.15 Filed MAR 13 1922 ROBERT R. KRAUTER  
Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 21 1921, to March 10 1922,

that I last saw her alive on March 9 1922,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH\* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 10 ds.

CONTRIBUTORY Diabetes Mellitus  
(Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Harkness M. D.

(Address) 1 E. Randall St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Olivet Cemetery

March 13 1922

20 UNDERTAKER

ADDRESS

J. F. Harkness 130 E. Fox

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY.



D 62281

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1919 Hemmiman Ave ST.)

WARD)

## 2-FULL NAME

(a) RESIDENCE. No. 1919 Hemmiman Ave

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

MAR 13 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9, 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1922, to March 9, 1922, that I last saw him alive on March 9, 1922, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. M. Robinson, M. D.

Address 310 1/2 Monument St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Labret Cemetery

March 14 1922

20 UNDERTAKER

ADDRESS

Edward Brown

1631 Arlene St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62282		HEALTH DEPARTMENT—CITY OF BALTIMORE		D 62282	
161-001					
CERTIFICATE OF DEATH.					
1-PLACE OF DEATH					
CITY OF BALTIMORE (No. 1210 17 June 10 ST. WARD)					
2-FULL NAME Baby Chambers					
(Residence in Baltimore: No. 1210 17 June St.; yrs., mos. ds.)					
REGISTERED NO. C					
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)					
PERSONAL AND STATISTICAL PARTICULARS.					
3-SEX. Male		4-COLOR OR RACE. Col.		5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Day (Write the word.)	
6-DATE OF BIRTH. Mar 10, 1912 (Month) (Day) (Year)					
7-AGE. If LESS than 1 day, yrs. mos. ds. hrs. or min.					
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).					
9-BIRTHPLACE. (State or Country). Balt.					
10-NAME OF FATHER. Harris Chambers					
11-BIRTHPLACE OF FATHER. Va.					
12-MAIDEN NAME OF MOTHER. Maggi Petilo					
13-BIRTHPLACE OF MOTHER. Va.					
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Maggi Chambers (Address) 1210 17 June					
15-					
16-DATE OF DEATH. Mar 12, 1912 (Month) (Day) (Year)					
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry. thereon and from the evidence obtained by said Inquest, autopsy or inquiry, that said deceased came to death on the day stated above. The CAUSE OF DEATH* was as follows: Premature birth.					
CONTRIBUTORY (Secondary) Duration yrs. mos. ds.					
(Signed) J. F. M. D. (Coroner) B-1423012 (Address) 49 St.					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence.					
19-PLACE OF BURIAL, OR REMOVAL, DATE OF BURIAL, 22 Burial Cemetery March 13, 1912					
20-UNDERTAKER ADDRESS Edward Bryon 1631 Orleans St.					
Filed MAR 13 1922 ROBERT A. KRAUTER, Burial Permit Clerk.					

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62283

CERTIFICATE OF DEATH.

164 D 62283

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 Lafayette Ave. ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Henrietta Hook

(a) RESIDENCE NO.

123 W. Lafayette Ave. ST. 11 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)  
Female White Widowed

5a If married, widowed, or divorced  
HUSBAND of John G. Hook  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 15" 1843

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
78 2 24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Eaglebeu  
(State or country) Germany

10 NAME OF FATHER Christian Erich

11 BIRTHPLACE OF FATHER (city or town) Germany  
(State or country)

12 MAIDEN NAME OF MOTHER. Christiana Beulet

13 BIRTHPLACE OF MOTHER (city or town) Germany  
(State or country)

14 Informant Mrs. Anna F. Hewitt  
(Address) 123 W. Lafayette Ave.

15 MAR 13 1922 ROBERT R. KRAUTER Registrar  
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 11" 19 22

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1922, to March 11, 1922, that I last saw her alive on March 11, 1922, and that death occurred, on the date stated above, at 2.50 A. m.  
The CAUSE OF DEATH\* was as follows:  
Acute dilatation of heart  
& pneumonia of lungs  
(duration) About three hours yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) About three hours yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) William H. Barone, M. D.

Mch. 13" 1922 (Address) 603 W. Baltimore St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR RE-MOVAL

Green Mount Cemetery

DATE OF BURIAL

Mar. 13" 1922

20 UNDERTAKER

Joseph B. Cook

ADDRESS

603 W. Baltimore St.

D 62284 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE

University Hospital  
Lambert & Green

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John Emmet Lupton Jr.

(a) RESIDENCE. No.

1413 Madison Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

— yrs.

3 mos.

12 da.

How long in U. S., if of foreign birth?

yrs.

mos.

da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Infant

6 DATE OF BIRTH (month, day, and year)

Nov-27-21

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3

12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

John Emmet Lupton

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Catherine A. Merrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Maryland

14 Informant

Dr. J. L. Lupton  
1413 Madison Ave.

15

MAR 13 1922

ROBERT R. KRAUTER  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar. 11

1922

17

I HEREBY CERTIFY, That I attended deceased from

3/10

1922, to

3/11/22

19

that I last saw him alive on

3/11/22

19

and that death occurred, on the date stated above, at

2:20 p.m.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia  
Right Lung

Unknown (duration) yrs. mos. da.

CONTRIBUTORY Zoon. Ophthalmia  
Malnutrition (duration) yrs. mos. 4 da.

18 Where was disease contracted

If not at place of death? 1413 Madison Ave.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Uterine finding  
(Signed) M. J. Jones, M. D.

3/11/22 (Address) University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cem

Mar. 13, 22

20 UNDERTAKER

Joseph B. Cook

ADDRESS

1413 Madison Ave.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



D 62285 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62285

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.: *1* WARD)

## 2-FULL NAME

(a) RESIDENCE. No. *522 S. Rose* ST.: \_\_\_\_\_ WARD. \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds.

yrs.

mos.

ds.

How long in U. S., if of foreign birth? *30* yrs. *0* mos. *0* ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed,

or Divorced (write the word)

*Married*

5a If married, widowed, or divorced

HUSBAND

(or) WIFE

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

MAR 13 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 10 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb. 28 1922* to *March 10 1922*that I last saw him alive on *March 10 1922*and that death occurred, on the date stated above, at *4:08 P. M.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Stomach*

(duration) ? yrs. mos. ds.

CONTRIBUTORY

Secondary

*Carcinomatosis and Cachexia* (duration) ? yrs. 2 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *yes* Date of *Mar 1, 1922*

Was there an autopsy?

*yes* *Findings suggest T. Pyogenic tons*

What test confirmed diagnosis?

(Signed) *John J. Griffin* M. D., 19 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Oak Lawn Cem* *Mar 14 1922*

20 UNDERTAKER

ADDRESS

*Peter Nicolaus* *2046 Eastern*

PHYSICIANS should state exact statement of OCCASION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

62286  
1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

ST.: 16 WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)  
Length of residence in city or town where death occurred

yrs.

mos.

ds. How long in U. S., if of foreign birth?

WARD.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb. 7-1862

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

60

1

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Dressmaker 069

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Department store

(c) Name of employer

Goldenberg Bros.

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore, Md.

10 NAME OF FATHER

Samuel Kurtz

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Anna Gorman

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Baltimore, Md.

14

Informant  
(Address)Mrs. Edwin M. Walker,  
3011 N. Gessman St.

MAR 13 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11 1922

17 I HEREBY CERTIFY, That I attended deceased from  
Mar 2 1922, to Mar 11, 1922.

that I last saw her alive on Mar 11, 1922

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia - Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

3/12/22

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cemetery

Mar. 14 1922

20 UNDERTAKER

ADDRESS

Mrs. Walker

924 E. Egle St.

D 62287

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62287

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 7

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE, NO.

ST..

WARD.

(Usual place of abode)

(If nonresident give city, town and State)

Length of residence in city or town where death occurred

- yrs. 3 - mos. -

ds. • How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

none

6 DATE OF BIRTH (month, day, and year)

Oct. 13-1899

7 AGE

Years 32

Months 4

Days 26

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Nebraska.

10 NAME OF FATHER

Wm. Worley

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ills.

12 MAIDEN NAME OF MOTHER

Frances Worrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Iowa.

14

Informant (Address)

Frances Worley  
721 N. Chester St.

15

Filed

MAR 13 1922

ROBERT R. KRAUTER,

Racial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 12 1922

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1922, to March 12, 1922, that I last saw him alive on March 12, 1922, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Haemoptysis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

Pulmonary Tuberculosis

(duration) 1 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Colorado &amp; Arizona (?)

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

J. M. D.

March 12, 1922

(Address) 214 S. Elmwood Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore

DATE OF BURIAL

March 14 1922

20 UNDERTAKER

Jirkler &amp; Jirkler

ADDRESS

1739 Eager

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62288

D 62288

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAR 13 1922

ROBERT H. KRAUTER, Registrar, Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from 3/12 1922 to 3/12 1922 that I last saw her alive on 3/12 1922.

and that death occurred, on the date stated above, at 5:10 a. m.

The CAUSE OF DEATH\* was as follows:

Asphyxia -

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90D 62289

D. 62289  
1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2224 McElderry ST., 7 WARD)

2. FULL NAME

Erwin J. Forster

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

2224 McElderry ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 3 mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb 8/07

7 AGE

15

Years

Months

Day

3

LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School

(b) General nature of industry, business, or establishment in which employed (or employer)

Boys' club

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Joseph Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Margaret Forster

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Margaret Burns 2224 McElderry

15

MAR 13 1922

ROBERT H. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Feb 11 1922

17

HEREBY CERTIFY, That I attended deceased from

March 1, 1922 to March 11, 1922

that I last saw him live on

March 11, 1922

and that death occurred, on the date stated above, at

5:15 A.M.

The CAUSE OF DEATH\* was as follows:

Myocardial Degeneration  
Acute Endocarditis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Acute Cardiac Degeneration

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death?

No

Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

Microscopic

(Signed)

3-12-22

(Address)

2224 McElderry

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Oak Lawn

DATE OF BURIAL

3/14 1922

20 UNDERTAKER

Philip Hennig

ADDRESS

2016 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62290

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 N. Collington ST., 89 WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 518 N. Collington ST., 89 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower5a If married, widowed, or divorced HUSBAND of late Mary E. Snyder (or WIFE of)6 DATE OF BIRTH (month, day, and year) Jan 24 - 467 AGE Years 76 Months 1 Days 14 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker(b) General nature of industry, business, or establishment in which employed (or employer) 088

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)10 NAME OF FATHER John Snyder11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)14 Informant Wm Snyder (Address) 518 N. Collington15 MAR 13 1922 ROBERT R. KRAUTER, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/10 192217 I HEREBY CERTIFY, That I attended deceased from 3-8-22 to 3-10-22 that I last saw him alive on 3-10-22, 1922and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH\* was as follows:

Angina Pectoris(duration) yrs. mos. 2 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. A. Seymour M. D.3/12/22 Address 2878 E Monument St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Mt. Carmel

DATE OF BURIAL

3/13 1922

20 UNDERTAKER

Philip Hennig ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 62291 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

Municipal Hospital, Bay View

CITY OF BALTIMORE: (No.

ST. 12 WARD

2-FULL NAME

Gertrude Litch

(a) RESIDENCE NO.

215 E. Lafayette

ST.

WARD

(Usual place of abode)

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred

8 yrs. mos.

How long in U. S., if of foreign birth

mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D 62291

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

A. Jackson Litch

6 DATE OF BIRTH (month, day, and year)

July 12, 1876

7 AGE

45 Years

Months

7

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Elkington, Del.

10 NAME OF FATHER

John Litch

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Maud Litch

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Philad, Pa

14

Informant (Address)

Thelma Litch 215 E. Lafayette Ave

15

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-11-1922

17

I HEREBY CERTIFY, That I attended deceased from

3-10, 1922, to 3-11, 1922

that I last saw her alive on 3-11, 1922

and that death occurred, on the date stated above, at 10:15 P. M.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Clyde Mendenhall M. D.

3-12-1922 (Address) Municipal Hospital, Bay View

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Woodlawn Cemetery, North

ADDRESS

William Cook 502 E. Nathan

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62292

HEALTH DEPARTMENT—CITY OF BALTIMORE

62292

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Garrison Ave*)ST.: *15* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Mildred West*

## (a) RESIDENCE. NO.

*Delco Home*

ST.

WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *11* yrs. — mos. — ds. How long in U. S., if of foreign birth? *11* yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Female White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Oct 22 1907*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*14**4*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Panama*

10 NAME OF FATHER

*Christopher R. West*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*New York*

12 MAIDEN NAME OF MOTHER

*Sally R. James*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Delaware*

14

Informant (Address)

*Sally R. James*

15

MAR 13 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Feb 13 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*July 15 1921, to Feb 13 1922*that I last saw him alive on *Feb 10 1922*and that death occurred, on the date stated above, at *1 a* m.

The CAUSE OF DEATH\* was as follows:

*Acute nephritis*(duration) yrs. *8* mos. ds.

CONTRIBUTORY (Secondary)

*Scarlet Fever*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Intestine*(Signed) *A. C. Connelley* M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Oak Lawn**Mar 13 1922*

20 UNDERTAKER

ADDRESS

*William Cook 502 E. North*

Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62293

## CERTIFICATE OF DEATH.

31 D 62293

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 9 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Generette(a) RESIDENCE. NO. 33rd and Taylor sts. ST.      WARD.       
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.      ds.      How long in U. S., if of foreign birth? yrs.      mos.      ds.     

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofNot stated6 DATE OF BIRTH (month, day, and year) 18677 AGE Years 55 Months      Days      If LESS than 1 day, hrs.      or min.     

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina10 NAME OF FATHER Jack Williams11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Dolly Fulmow13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina14 Informant Hospital Records  
(Address) M.T.H.15 MAR 13 1922 19 ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11, 192217 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1921 to March 11, 1922that I last saw her alive on March 11, 1922and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(duration) 1 yrs. 1 mos.      ds.CONTRIBUTORY Pulmonary hemorrhages  
(Secondary)(duration)      yrs. 12 mos.      ds.18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date of     Was there an autopsy?     What test confirmed diagnosis? T.B. in sputum, X-ray(Signed) John T. Aubrey M. D.3-11-22, (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

M.T.H. 3/14/22

20 UNDERTAKER ADDRESS

Samuel Heenrichs 578

is very important. See instructions on back of certificate.

D 62294 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62294  
(Jasionoski) ✓  
160

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3408 West St.) St. 1 Ward

Registered No. C. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

William Jasionowski

(Residence in Baltimore: No. 3408 West St. St.; yrs. .... mos. .... 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male 4-COLOR OR RACE, white 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, March 12, 1922 (Month) (Day) (Year)

7-AGE, 1 yrs. .... mos. .... ds. If LESS than 1 day, hrs. or .... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, none (b) General nature of industry, business, or establishment in which employed (or employer), 000

9-BIRTHPLACE, (State or Country), Baltimore Md

10-NAME OF FATHER, William Jasionowski

11-BIRTHPLACE OF FATHER, (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER, Josephine Budzinski

13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), William Jasionowski

(Address), 3408 West St

15- MAR 13 1922 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 13, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Congestive Heart Failure

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(Signed) Charles Shaw M. D. (Coroner) March 13, 1922 (Address) 1804 Stoddard St

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Holy Rosary March 13, 1922

20-UNDERTAKER, ADDRESS

John M. Weber 1803 Bank St

is very important. See instructions on back of certificate. Exact statement of OCCUPATION

D 62295

HEALTH DEPARTMENT—CITY OF BALTIMORE

170 D 62295

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Stagnum Hospital* St. *20* Ward)

Registered No. C.....

2-FULL NAME

(Residence in Baltimore: No. *1948 W Pratt* St.; yrs., *36* mos. .... ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, (Write the word) *Single*

6-DATE OF BIRTH, *May 1 1878* (Month) (Day) (Year)

7-AGE, *43* yrs., *40* mos., *10* ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Night Watchman* (b) General nature of industry, business, or establishment in which employed (or employer), *Wilson Meat Co*

9-BIRTHPLACE, (State or Country), *Philadelphia*

10-NAME OF FATHER, *James G. Fleming*

11-BIRTHPLACE OF FATHER, (State or Country), *Philadelphia*

12-MAIDEN NAME OF MOTHER, *Elizabeth Turner*

13-BIRTHPLACE OF MOTHER, (State or Country), *England*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harry Fleming*

(Address) *2640 Wilkens Ave*

15-

File *MAR 13 1922* ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *March 11 1922* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH\* was as follows: *Bullet wound, Brain*  
*Self inflicted Gunshot*  
*while in dependent mood*  
(Duration) .... yrs. .... mos. *4* ds.

CONTRIBUTORY (Secondary) (Duration) .... yrs. .... mos. .... ds.

(Signed) *James M. Rulon* M. D. (Coroner.)  
*Mar 12 1922* (Address) *700 E. Charles St*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place *Stagnum Hospital* In the of death *4* yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? *Foot of Brunswick St*

Former or usual residence *1948 W. Pratt St*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *Western Cemetery Mar 13 1922*

20-UNDERTAKER, ADDRESS *Geo. H. Schwan 401 E. Pratt Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62296

## CERTIFICATE OF DEATH.

113 D 62296

## 1-PLACE OF DEATH

CITY OF BALTIMORE:

2016 Wilhelms

ST.: 70 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Ruth. Reitz

## (a) RESIDENCE. NO.

2016 Wilhelms

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

7

mos.

11

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed,

Single

or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

July 28, 1921

7 AGE

Years

Months

Days

LESS than

1 day, hrs.

or min.

7

11

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

house

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore

10 NAME OF FATHER

Julius Reitz

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Edith Rosenbaum

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Baltimore

## PARENTS

14 Informant  
(Address)Julius Reitz  
2016 Wilhelms St.

## 15

MAR 13 1922

ROBERT R. KRAUTER,

Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 10 1922

17

I HEREBY CERTIFY, That I attended deceased from

February 27, 1922, to March 11, 1922,

that I last saw him alive on March 10, 1922,

and that death occurred, on the date stated above, at 2 4, m.

The CAUSE OF DEATH\* was as follows:

Dysentery Acute.

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

Dysentery (duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert R. Krauter, M. D.

3/11/22 (Address) 2151 Wilhelms Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer

MAR 13 1922

20 UNDERTAKER

ADDRESS

Geo. H. Schwab, 2101 E. Ave.



Is very important. See instructions on back of certificate.

D 62297 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 12 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Ridgeway Wilcox

(Residence in Baltimore: No. 1701-N-Charles-St. (12-Ward) St.; yrs. 63 yrs. 7 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-Single, Married, Widowed or Divorced, Married  
(Write the word.)

6-DATE OF BIRTH, August 5 1858  
(Month) (Day) (Year)

7-AGE, 63 yrs. 7 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:  
(a) Trade, profession, kind of work, Locomotive Engineer  
(b) General nature of industry, business, or establishment in which employed (or employer), Penna. R. R. Co.

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Charles Harmon Wilcox

11-BIRTHPLACE OF FATHER, (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Harriet Ann Brown

13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elizabeth C. Wilcox (wife)  
(Address) 1701-N-Charles-St., City.

15- ROBERT R. KRAUTER,

File MAR 13 1922 Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 11 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry,) thereon and from the evidence obtained by said inquest find that said deceased came to his death (Inquest, autopsy or inquiry,) on the day stated above.

The CAUSE OF DEATH\* was as follows:

Crushed heart  
Leaves by 8:30  
Am bus  
(Duration) yrs. mos. ds.  
CONTRIBUTORY (Secondary) Pa. R.R. Engine dragged

(Signed) W. H. M. J. M. D.  
Mar 11 1922 (Address) 1025

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).  
At place of death, 3 hrs In the 63 yrs. 7 mos. 6 ds.

Where was disease contracted, if not at place of death? on the Penna. R. R.  
Former or usual residence 1701-N-Charles-St.

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery DATE OF BURIAL, Mar-13-22

20-UNDERTAKER, STEWART & MOWEN COMPANY ADDRESS 108 W. NORTH AVE.  
(WILLIAM F. WOODEN, Successor)

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 62298

74-001  
D 62298

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1404 Cairo*)

ST. *19* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

*Ella Johnson*

(Residence in Baltimore: No. *1404 Cairo St.*)

*30*  
St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Female*

4-COLOR OR RACE

*colored*

5-SINGLE,

*widow*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

*November*, *1869*  
(Month) (Day) (Year)

7-AGE,

*53* yrs. mos. da.

IT LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

*Housework*  
*070*

9-BIRTHPLACE,

(State or Country).

*Md.*

10-NAME OF FATHER,

*Moses Austin*

11-BIRTHPLACE OF FATHER,

(State or Country).

*Md.*

12-MAIDEN NAME OF MOTHER

*Louisa Ward*

13-BIRTHPLACE OF MOTHER,

(State or Country).

*Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Emma Nolan*

(Address)

*4832 W. 1st St., Catonsville*

15-

File

*MAR 13 1922*

ROBERT R. KRAUTER

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*March 10*, *1922*  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*  
(Inquest, au-

*quity* find that said deceased came to *her* death  
topsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Cerebral hemorrhage*

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

*no history*

(Duration) yrs. mos. da.

(Signed) *J. T. Hennessy*, M. D.  
(Coroner)

*March 12 1922* (Address) *2802 E. Baltimore Ave.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.... yrs. .... mos. .... da. State.... yrs. .... mos. .... da.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Anthony's*

*Mar 14, 1922*

20-UNDERTAKER

ADDRESS

*Blair & Freedland*

*1140*

62299

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 62299

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1026 McCullough St

REGISTERED NO.

CITY OF BALTIMORE: (No.

ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Bernice Woodfall

(a) RESIDENCE. NO.

1026 McCullough St.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

colored

5 Single, Married, Widowed, or Divorced (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

infant

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

Jack Woodfall

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

Rose Thornton

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Mother

JOHNS HOPKINS HOSPITAL

15

MAR 13 1922

ROBERT R. KRAUTER  
Burial Permit Clerk.

20 UNDERTAKER

Commissioner Health,

Per. Wm. E. Woodall

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 21 1922 to March 8 1922

that I last saw him alive on March 4 1922

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH\* was as follows:

Hemorrhagic disease  
of new born -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? signs &amp; symptoms

(Signed) Geo. E. Mills M. D.

, 19 (Address) Univ. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

MAR 11 1922

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

6-9-19-H. P. Co.-1000 Bks.  
D62300 HEALTH DEPARTMENT—CITY OF BALTIMORE D62300

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1355 N. Carey ST. 15 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Glora May Aikens

(a) RESIDENCE. No.

1355 N. Carey

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 10 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Orange Aikens

6 DATE OF BIRTH (month, day, and year) April 24, 1885 7 AGE Years 36 Months 10 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer) Self (c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

James Sheridan

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Mary Pickett

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address) James Sheridan Baltimore

15

MAR 13 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11, 1922

17

I HEREBY CERTIFY, That I attended deceased from March 7, 1922, to March 11, 1922, that I last saw her alive on March 11, 1922, and that death occurred, on the date stated above, at 9:40 A. M. The CAUSE OF DEATH\* was as follows:

Acute Cordiac Dilatation & Arrhythmia.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. 2 mos. 2 ds. (duration) yrs. 2 mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical (Signed) W. H. Wright M. D. (Address) 1209 Presb. St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Trinity M. A. Burial Ground Mar 14 1922

20 UNDERTAKER

George H. Hollander 1631 Grand Hill Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62301

## CERTIFICATE OF DEATH.

D 62301

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Alhambra apt 13* ST. *13* WARD)

## 2-FULL NAME

(a) RESIDENCE NO. *Alhambra apt*

(Usual place of abode)

Length of residence in city or town where death occurred *1 year* mos.ST. *13*

WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, write the word *Married*5a If married, widowed, or divorced, HUSBAND of (or) WIFE of *Adolph Koenigsberg*6 DATE OF BIRTH (month, day, and year) *Feb 13 1915*

7 AGE

Years *76*Months *6*

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *Isaac Granbaum*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Leine Granstein*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14

Informant (Address) *Mr. Hecht Alhambra apt 13*

15

MAR 13 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 13 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Nov 9* 19 *21* to *Nov 13* 19 *22*; that I last saw him alive on *Nov 12* 19 *21*; and that death occurred, on the date stated above, at *3:45 a.m.*

The CAUSE OF DEATH\* was as follows:

*Uremia*

(duration)

yrs.

mos.

ds. *3*CONTRIBUTORY (Secondary) *Myocardial Infarction*(duration) *3* yrs.

mos.

ds.

18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *no*

Date of

Was there an autopsy? *no*What test confirmed diagnosis? *Clinical*(Signed) *Harold J. Harkness*

M. D.

Address) *313 Lake Court Apt*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

*Baltimore*

DATE OF BURIAL

*Feb 14 1922*

20 UNDERTAKER

*Harold J. Harkness*

ADDRESS

*1182 W. 4th St.*

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 62302

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62302

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Henry A. Butcher

## (a) RESIDENCE. No.

206 Harrison St.

## WARD

Syracuse, N.Y.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown ds. How long in U. S., if of foreign birth? 179 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of Bessie Butcher

(or WIFE of)

## 6 DATE OF BIRTH (month, day, and year)

Jan. 27, 1882

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

40110

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Training officer

(b) General nature of industry, business, or establishment in which employed (or employer)

086

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Illinois

## 10 NAME OF FATHER

John C. Butcher

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia

## 12 MAIDEN NAME OF MOTHER

Maria S. Dalby

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Illinois14 Informant JOHNS HOPKINS HOSPITAL

(Address)

## 15 Filed

19

ROBERT R. KRAUTER,

Registrar

MAR 13 1922Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Mar. 10, 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

March 6, 1922, to March 10, 1922that I last saw him alive on March 10, 1922and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary oedemauremiachronic nephritis(duration) 2 yrs. — mos. — ds.

## CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

## 18 Where was disease contracted

if not at place of death?

Syracuse, N.Y.Did an operation precede death? no Date of —Was there an autopsy? no

What test confirmed diagnosis?

Urine analysis(Signed) E. C. Andrews, M. D.

3/11, 1922 (Address)

Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

National Cemetery3/14/22

## 20 UNDERTAKER

## ADDRESS

Chas. J. Evans & Son 1180 Mt. Royal Ave.

D 62303

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62303

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 Light St. ST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

512 Parkin

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John M. Giff

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

53

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

James Byrne

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

John M. Giff 429 S. 1st St.

15

MAR 13 1922

ROBERT R. KRAUTER Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1922, to March 12, 1922.that I last saw her alive on March 12, 1922.and that death occurred, on the date stated above, at 9:10 A. M.

The CAUSE OF DEATH\* was as follows:

Diabetes Mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Chronic Nephritis, Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? At homeDid an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Carl F. Benson M. D., 19 (Address) South Baltimore General Hospital

\*State the Disease Causing Death, or (in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Charles Cemetery Mar 10 1922

20 UNDERTAKER

John J. Cavanagh ADDRESS 401 Hallway

TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62304

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

13 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

13 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAR 13 1922

ROBERT R. KRAUTER, Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from 3/16/22, 1922, to 3/12/22, that I last saw him alive on 3/12/22, and that death occurred, on the date stated above, at 7-40 m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

, 19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62305

D 62305

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2724th. Chas. St. 15 WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

20 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

20 yrs.

mos.

ds.

WARD.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,

or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15

Filed

MAR 13 1922

Registrar

ROBERT R. KRAUTER

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, that I attended deceased from

that I last saw

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY

(Secondary)

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

101 D 62306

## CERTIFICATE OF DEATH.

D 62306

1 PLACE OF DEATH

Hebrew Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 13 WARD)

2-FULL NAME

Sadie Fisher

(a) RESIDENCE. NO.

Melma Apts Brookefield

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Harry S Fisher

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

37

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Philip Zentz

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Molly

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant (Address)

No

15

Filed

ROBERT H. KRAUSE

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 13 1922

17

I HEREBY CERTIFY, That I attended deceased from

Mar 11, 1922, to March 13, 1922.

that I last saw her alive on March 13, 1922.

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

Broncho pneumonia

(duration) yrs. mos. 16 ds.

18 Where was disease contracted

If not at place of death?

At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Physical Examination

(Signed)

Moses Saulson M.D.

, 19 (Address)

Hebrew Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Mt Carmel

3/13/22

20 UNDERTAKER

ADDRESS

Jacob Lewis 1439 E. Baltimore

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Lobar. Another  
abnormal condition.*

D 62307

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED No. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No.

St. yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE,

Colored

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

## 6-DATE OF BIRTH,

191, 1916  
(Month) (Day) (Year)

## 7-AGE,

6 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Schoolboy

9-BIRTHPLACE,  
(State or Country),

Maryland

## 10-NAME OF FATHER,

Louis Die

11-BIRTHPLACE OF FATHER  
(State or Country),

Maryland

## 12-MAIDEN NAME OF MOTHER

Bertha Smith

13-BIRTHPLACE OF MOTHER  
(State or Country),

Maryland

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Charles Mills

(Address)

650 Bradley

## 15-

Robert P. Harrison,

Burial Permit Clerk.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

12 Mar, 1912  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Mar 11, 1912, to Mar 12, 1912,

that I saw him alive on Mar 11, 1912,

and that death occurred, on the date stated above, at 6:15 A.M.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) William E. Bawlin M. D.

Mar 12, 1912 (Address) 762 E. E. Plume

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn et

## DATE OF BURIAL,

Mar 12, 1912

## 20-UNDERTAKER

J. E. Brown &amp; Son

## ADDRESS

108 W. Madison

Important. See instructions on back of certificate.



D 62308

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62308

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Seibert(a) RESIDENCE. No. UnknownST. 76 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Unknown</u>
----------------------	---------------------------------	---

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, .... hrs. or .... min.
<u>59</u>	<u>--</u>	<u>--</u>	<u>--</u>	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cement Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,  
(State or country) Maryland10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown  
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)14 Informant Hospital Records,  
(Address) Municipal Hospital,15 Filed 1922 19 Registrar Johns Hopkins Hospital

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1922

17 I HEREBY CERTIFY, That I attended deceased from February 2, 1921, to March 9, 1922, that I last saw him alive on March 8, 1922, and that death occurred, on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH\* was as follows:

Broncho pneumonia(duration) yrs. mos. 3 ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
If not at place of death?Did an operation precede death? ne Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde M. Wilson

M. D.

3/13/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITALMAR 13 1922

20 UNDERTAKER

Commissioner Health,

ADDRESS

POT. WM. E. WOODALL

Exact statement of cause of death is very important. See instructions on back of certificates.

D 62309 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 5 ST. WARD)

2-FULL NAME

(Residence in Baltimore: No. 1234 Edward St.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.  
(State or Country).

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER  
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

101

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)

(Signed)

(Coroner)

(Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs... mos... ds. In the... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

important. See instructions on back of certificate.

ROBERT J. HARTMAN

JOHNS HOPKINS HOSPITAL

Commissioner of Health

MAR 1 1922

D 62310 HEALTH DEPARTMENT—CITY OF BALTIMORE 62310

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 3510 Fleet

ST. 46 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Charles Masson Jr

## (a) RESIDENCE. NO.

3510 Fleet

ST. 26 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male white

## 4 COLOR OR RACE

## 5 Single, Married, Widowed,

or Divorced (write the words)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Jan 18<sup>th</sup> 1920

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

2

2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore

## 10 NAME OF FATHER

Charles Masson

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Baltimore

## 12 MAIDEN NAME OF MOTHER

Pearl Maltz

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Baltimore

## 14

Informant  
(Address)Charles Masson  
3510 Fleet St

9191922

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 11 1922

17

I HEREBY CERTIFY, That I attended deceased from

3 10 1922, to 3 11 1922,

that I last saw him alive on 3 11 1922,

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration)

yrs.

mos.

da.

CONTRIBUTORY  
(Secondary)

Acute Myocarditis

(duration)

yrs.

mos.

da.

18 Where was disease contracted  
if not at place of death?

Unknown

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Observation

(Signed)

H. B. Jellow M. D.

3/11 1922

Address 315 S. Highland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Carmel Cem.

## DATE OF BURIAL

March 12 1922

## 20 UNDERTAKER

Lilly &amp; Feik

## ADDRESS

403 S. Waverly

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior.*



HEALTH DEPARTMENT—CITY OF BALTIMORE **D 62311****D 62311**

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *7107 Hilton* ST.: *15* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Thomas P. Gaughron*(a) RESIDENCE. NO. *7107 Hilton* ST., *15* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Male**White.**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct. 6-1868*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*53**5**6*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Chief*

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*

10 NAME OF FATHER

*Thomas Gaughron*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ireland.*

12 MAIDEN NAME OF MOTHER

*Catherine Lynch*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ireland.*

14

Informant (Address)

*Mary E. Pfister (Sister) 7107 Hilton St.*

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 12 1922*

17

I HEREBY CERTIFY, That I attended deceased from *July 10-*, 1922, to *Mar. 12*, 1922, that I last saw him alive on *Mar. 12*, 1922, and that death occurred, on the date stated above, at *10.48* a.m. The CAUSE OF DEATH\* was as follows:*Fibroid. Tuberculosis of R. Lung 7 cm. to 4 cm. (duration) yrs. mos. ds.*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Thos. H. Maynard M. D.*

19

(Address)

*14. East. Read St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Redeemer Cew.**March 15 1922*

20 UNDERTAKER

*Lilly E. Ziller*

ADDRESS

*403 S. Wolfe St.*

THIS IS VERY IMPORTANT. See instructions on back of certificates.

8 1922

154240  
D 62312

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

57 D 62312

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST.: 1 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Gowalski(a) RESIDENCE. NO. 2200 St. Collington ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 11 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of Steve Gowalski Husband6 DATE OF BIRTH (month, day, and year) April 9/18997 AGE Years 22 Months 11 Days 3 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W. 001

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland10 NAME OF FATHER Steven Karcinkowski11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland12 MAIDEN NAME OF MOTHER Josephine Poliff13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland14 Informant JOHNS HOPKINS HOSPITAL (Address) Records15 Filed 19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 192217 I HEREBY CERTIFY, That I attended deceased from March 3, 1922, to March 12, 1922, that I last saw her alive on March 12, 1922, and that death occurred, on the date stated above, at 2:15 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Embolism(duration) yrs. mos. ds. Instantaneous

## CONTRIBUTORY

(Secondary) Rheumatic endocarditis Duration 10 years18 Where was disease contracted if not at place of death? at homeDid an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Francis R. Dieulaide, M. D.12, 1922 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Rosary Cem. Mar 14 1922

20 UNDERTAKER

ADDRESS

Jacob Dzialowski 121 S. Bond

THIS IS VERY IMPORTANT. See instructions on back of certificate.

D 62313

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1818 Barclay

ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Chester Ross, Jr.

(a) RESIDENCE. NO. 1818 Barclay  
(Usual place of abode)

ST. WARD.

Length of residence in city or town where death occurred 0 yrs. 11 mos. 6 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male

White

S.I.D.G.L.F.

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 6, 1921.

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
0 11 6

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland

10 NAME OF FATHER George Chester Ross

11 BIRTHPLACE OF FATHER (city or town) North Carolina  
(State or country)

12 MAIDEN NAME OF MOTHER Julia E. Henze

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co., Maryland  
(State or country)14 Informant George C. Ross  
(Address) 1818 Barclay Street

15 Filed 19 3 1922 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 12, 1922

17 I HEREBY CERTIFY, that I attended deceased from Mar 7, 1922, to Mar 12, 1922, that I last saw him live on Mar 12, 1922, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Morrison, M. D.

(Address) 3632 Roland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Mary's Cemetery

3/14, 19 22

20 UNDERTAKER

ADDRESS

Henry W. Mears &amp; Son 805 N. Calvert

D 62314

HEALTH DEPARTMENT—CITY OF BALTIMORE D 62314

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1521 Mc Henry ST., 19 WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 1521 Mc Henry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George J. Bee

6 DATE OF BIRTH (month, day, and year) Mar. 1858

7 AGE Years 63 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER Owen Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Cath. McVay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Cath. McIntyre

15 REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1922

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1922, to March 11, 1922, that I last saw her alive on March 4, 1922, and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Edw. V. Coolahan M. D.

3/13, 1922 (Address) 24 N. Fulton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral

20 UNDERTAKER

John A. Moran 3000 E. Fulton

DATE OF BURIAL

114 1922

ADDRESS

E. Fulton

TION is very important. See instructions on back of certificates.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

No hemorrhage.  
Primary arteries  
Sclerotic

D 62315 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Wesman's Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

Mrs Mary O'Melia

(a) RESIDENCE NO.

3004 E Balto St.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 18, 1867

7 AGE

55

Years

Months

Days

2

23

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

Thomas Golder

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Margaret Loftis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant

(Address)

Margaret O'Brien 3004 E Baltimore St.

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11, 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 6, 1922, to March 11, 1922

that I last saw her alive on March 11, 1922

and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH\* was as follows:

Surgical Shock

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ovarian tumor, malignant, with secondary carcinoma (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of March 11, 1922

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) J. H. Duncan M. D.

3/11, 1922 (Address) Wesman's Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral

DATE OF BURIAL

3/12, 1922

20 UNDERTAKER

John A. Moran 3000 E Balto.

TION is very important. See instructions on back of certificates.

8-1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 62316

D 62316

## CERTIFICATE OF DEATH.

47

## 1. PLACE OF DEATH

CITY OF BALTIMORE (No. 717 Roland Ave. 13 ST. WARD)

## 2. FULL NAME

Margaret D. Byrne

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

717 Roland Ave. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James J. Byrne

6 DATE OF BIRTH (month, day, and year) Mar 7-1862

7 AGE Years 60 Months 0 Days 5 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W. 500

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

## 10 NAME OF FATHER

Patrick Dunbar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

## 12 MAIDEN NAME OF MOTHER

Ann Dooley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

## 14

Informant (Address) Sister 717 Roland Ave

## 15

Robert F. Harrison, Registrar

3 1922

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/12 1922

17 I HEREBY CERTIFY, That I attended deceased from 3/7 1922, to 3/12 1922, that I last saw him alive on 3/11 1922, and that death occurred, on the date stated above, at 12:50 A.M.

The CAUSE OF DEATH\* was as follows:

Causes (Cancer) of lung, recurrent from Caution of Breast.

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

Pulmonary edema

(duration) yrs. mos. 2, ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of 3/10/22

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Moran, M. D.

3/12 1922 (Address) 804 Cathedral St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral

DATE OF BURIAL

3/14 1922

20 UNDERTAKER

John A. Moran 3000 E. Balt.





D 62318

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62318

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Municipal Hosp. Bay View* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Ella Thomas Mozley*(a) RESIDENCE. No. *523 Lombard St.* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *10* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F* 4 COLOR OR RACE *Col* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Jan 1900*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *45 or 53?*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Vall-S.*10 NAME OF FATHER *Not known*11 BIRTHPLACE OF FATHER (city or town) (State or country) *U.S.*12 MAIDEN NAME OF MOTHER *Not known*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *U.S.*14 Informant (Address) *Harry Reed*15 *3-19-22* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-9-1922*17 I HEREBY CERTIFY, That I attended deceased from *2-21-1922* to *3-9-1922* that I last saw *her* alive on *3-4-1922*and that death occurred, on the date stated above, at *4:15 PM*  
The CAUSE OF DEATH\* was as follows:*Mediastinal tumor (anurysm)*  
(duration) *1* yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *Y*What test confirmed diagnosis? (Signed) *Clayton McNeill*, M. D.3-11-1922 Address *Municipal Hosp Bay View*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Not known* *March 13 1922*20 UNDERTAKER *James E. Eason* ADDRESS *916 N. ...*

This is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Primary luetec  
infection.*

D 62319

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62319

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal HospitalST.: 18 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Mason(a) RESIDENCE. No. 871 Raborg St.

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18757 AGE Years Months Days If LESS than 1 day, hrs. or min.  
46 -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,  
(State or country) Maryland10 NAME OF FATHER Jim Hoshell11 BIRTHPLACE OF FATHER (city or town) Balto.,  
(State or country) Maryland12 MAIDEN NAME OF MOTHER Ella Queen13 BIRTHPLACE OF MOTHER (city or town) Balto.,  
(State or country) Maryland14 Informant Hospital Records,  
(Address) Municipal Hospital.15 3 1922 Robert F. Harrison,

Burial Permit Clerk,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 19 2217 I HEREBY CERTIFY, That I attended deceased from March 1, 19 22, to March 9, 19 22, that I last saw her alive on March 9, 19 22, and that death occurred, on the date stated above, at 11 P.M. m.  
The CAUSE OF DEATH\* was as follows:Chronic nephritis

(duration) / yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clute McNeil, M. D.5/10/22 Address Municipal Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

mt aebu orMarch 13 1922

20 UNDERTAKER

Daniel EarlsADDRESS 916Baltimore

See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62320

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.;

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

## (a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

How long in U. S., if of foreign birth?

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced (write the word)

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant JOHNS HOPKINS HOSPITAL (Address)

## 15

Filed

ROBERT P. Harrison

Registrar

3 1922

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 192217 I HEREBY CERTIFY, That I attended deceased from Feb. 24 1922 to March 13 1922that I last saw him alive on March 13 1922and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH\* was as follows:

Post-operative shock(duration) yrs. mos. 1 1/2 ds.

## CONTRIBUTORY (Secondary)

Hydrocephalus(duration) 2 yrs. 8 mos. 1 ds.

## 18 Where was disease contracted

if not at place of death? Conjugal - born S.C.Did an operation precede death? Yes Date of 3-12-22Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W. Arfield M. Firon, M. D., 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Wagener S. C.3/13 1922

## 20 UNDERTAKER

## ADDRESS

Jack Lewis 439 E. Baltimore



D 62321

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62321

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal HospitalST.: 7

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Mills(a) RESIDENCE. No. 717 N. Register St.

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

42

--

--

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Chester,  
(State or country) Pennsylvania10 NAME OF FATHER George Mills11 BIRTHPLACE OF FATHER (city or town) Chester,  
(State or country) Pennsylvania12 MAIDEN NAME OF MOTHER Marjorie Boneal13 BIRTHPLACE OF MOTHER (city or town) Magnolia,  
(State or country) Delaware.

14

Informant Hospital Records,  
(Address) Municipal Hospital.

15

3 1922 Robert P. Hamilton,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 19 22

17

I HEREBY CERTIFY, That I attended deceased from February 23 19 22, to March 12 19 22.that I last saw him alive on March 12 19 22.and that death occurred, on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH\* was as follows:

Syphilis(duration) 20 yrs. mos. ds.CONTRIBUTORY Syphilitic Aortic  
(Secondary) Insufficiency (duration) 4 yrs. mos. ds.18 Was disease contracted  
1 not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Harrison Clinical(Signed) Clyde McNeil M. D.3/19/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Trinity CemMon 14/22

20 UNDERTAKER

ADDRESS

Wm. Cook702 E. North

This is very important. See instructions on back of certificates.

D 62322

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62322

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Robt Garrett Hospital for Children* REGISTERED NO. *100-001*  
 CITY OF BALTIMORE: (No. *27 N. Carey* ST.: *18* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
 2-FULL NAME *William Erdman*  
 (a) RESIDENCE. NO. *921 N. Baltimore* ST., \_\_\_\_\_ WARD. \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred *Life* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Single*  
 5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Child*  
 6 DATE OF BIRTH (month, day, and year) *Sept 1921*  
 7 AGE Years \_\_\_\_\_ Months *5* Days *16* If LESS than 1 day, hrs. \_\_\_\_\_ or min. \_\_\_\_\_  
 8 OCCUPATION OF DECEASED  
 (a) Trade, profession or particular kind of work *Child*  
 (b) General nature of industry, business, or establishment in which employed (or employer) *Child*  
 (c) Name of employer *Child*

9 BIRTHPLACE (city or town) (State or country) *Balto*  
 10 NAME OF FATHER *Geo - Erdman*  
 11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto*  
 12 MAIDEN NAME OF MOTHER *Susie Erdman*  
 13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto*

14 Informant *Susie Erdman*  
 (Address) *921 N. Baltimore St.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 13 1922*  
 17 I HEREBY CERTIFY, That I attended deceased from *July 16<sup>th</sup>*, 19 *22*, to *March*, 19 *22*, that I last saw him alive on *March 12*, 19 *22*, and that death occurred, on the date stated above, at *1<sup>st</sup> A.* m.  
 The CAUSE OF DEATH\* was as follows:

*Pneumo Pneumonia*

(duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY *Purulent Otitis Media & Acidosis*  
 (Secondary) (duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted if not at place of death? *unknown*

Did an operation precede death? *no* Date of \_\_\_\_\_

Was there an autopsy? *yes*

What test confirmed diagnosis? *findings*

(Signed) *J. H. W. Clift* M. D.

*3/13, 1922* Address *27 N. Carey*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*St-Marys Hampden*

20 UNDERTAKER  
*Wm. Cook*

DATE OF BURIAL

*Mar 14/ 19 22*

ADDRESS  
*502 E. North*

THIS IS VERY IMPORTANT. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributor (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (mere symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Otitis media secondary  
to broncho pneumonia  
No infection factor  
to pneumonia.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62323

62323

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

2042 E. Eager

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2042 E. Eager

ST.

WARD)

2-FULL NAME

Mrs. Jennie Viola Langkam

(a) RESIDENCE NO.

2042 E. Eager

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

William Langkam

6 DATE OF BIRTH (month, day, and year)

Oct 19 1867

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

60

yrs.

mos.

4

12

days

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

York Co. Penn.

10 NAME OF FATHER

John Souder

11 BIRTHPLACE OF FATHER (city or town) (State or country)

York Co. Penn.

12 MAIDEN NAME OF MOTHER

Elizabeth Schuler

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

York Co. Penn.

14

Informant (Address)

William Langkam

15

Informant (Address)

2042 E. Eager

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13/22, 19

17

I HEREBY CERTIFY, That I attended deceased from

Jan 6, 1922, to Mar 13, 1922

that I last saw her alive on Mar 13, 1922

and that death occurred, on the date stated above, at 7:00 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic tests

(Signed) C. W. Macdonald, M. D.

(Address) 1546 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Woodlawn

20 UNDERTAKER

Wm. Cook

DATE OF BURIAL

Mar 14 1922

ADDRESS

505 E. N. 10

TION is very important. See instructions on back of certificates.



D-62324 HEALTH DEPARTMENT—CITY OF BALTIMORE 001 D 62324

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2300 Reisterstown ST., 101 WARD)

## 2-FULL NAME

Mary E Roberts

## (a) RESIDENCE NO.

2300 Reisterstown Road

(Usual place of abode)

Length of residence in city or town where death occurred

75 yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widow

## 5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Thos. Roberts

## 6 DATE OF BIRTH (month, day, and year)

Unknown

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

About 75

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

## 10 NAME OF FATHER

Wm. Mills

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

## 12 MAIDEN NAME OF MOTHER

Elyse Allison

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

## 14

Informant (Address)

Mr. Richard Keating 2300 Reisterstown Road

## 15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Mar 11 1922

## 17

I HEREBY CERTIFY, that I attended deceased from

Mar 5 1922 to Mar 11 1922

that I last saw her alive on Mar 11 1922

and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O. O. Lloyd M. D.

19 (Address) 2232 E. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Korramie Cem

## DATE OF BURIAL

Mar 14 1922

## 20 UNDERTAKER

Wm. Dickman &amp; Son North Ave.

D 62325

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62325

## CERTIFICATE OF DEATH.

31

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2138 Walbrook Ave ST.: 15 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Viola T. Blumenauer(a) RESIDENCE. No. 2138 Walbrook Ave ST. 15 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
------------------------	---------------------------------	---

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Oct 26-1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	<u>38</u>	<u>4</u>	<u>16</u>	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick City  
(State or country) Md.10 NAME OF FATHER John Blumenauer11 BIRTHPLACE OF FATHER (city or town) Frederick City  
(State or country) Md.12 MAIDEN NAME OF MOTHER Susan Miller13 BIRTHPLACE OF MOTHER (city or town) Frederick City  
(State or country) Md.14 Informant Edna Cecit  
(Address) 2138 Walbrook Ave15 Robert P. Harrison,  
RegistrarBurial Permit Clark

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1921 to March 12 1922 that I last saw him alive on March 12 1922 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosisabout(duration) 12 yrs. mos. ds.CONTRIBUTORY Pulmonary tuberculosis  
(Secondary) about(duration) 12 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

Signed W. B. Webbitt M. D.3/15/22 (Address) 2220 Garrison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Woodlawn Cemetery, Md. 192220 UNDERTAKER ADDRESS 1944Narry W. Ehlert W. North

See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62326

D 62326

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *45 Maryland Ave* ST. *75* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

## (a) RESIDENCE. NO.

*45 Maryland Ave*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *1* yrs. *2* mos. *15* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*white*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Single*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Dec. 27-1920*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*1**2**15*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Baltimore*

## 10 NAME OF FATHER

*Harry T. Ellis*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*

## 12 MAIDEN NAME OF MOTHER

*Florence G. Neal*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*MD*

## 14

Informant (Address)

*Harry T. Ellis**45 Maryland Ave*

## 15

Filed

*Robert F. Harrison*

Registrar

13 1922

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 12 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Feb 9*, 19*22* to *March 2*, 19*22*.that I last saw him alive on *March 12*, 19*22*.and that death occurred, on the date stated above, at *3 P.* m.

The CAUSE OF DEATH\* was as follows:

*Heart Disease*(duration) *no* yrs. *1* mos. *-* ds.

## CONTRIBUTORY (Secondary)

*Bronchopneumonia*(duration) *no* yrs. *no* mos. *6* ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *-*Was there an autopsy? *no*What test confirmed diagnosis? *Examination*

(Signed)

, 19 (Address)

*Lakeland*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Landon Park Cem**Mar 14 1922*

## 20 UNDERTAKER

*Harry W. Ehlen*

## ADDRESS

*1988 W. North Ave*

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Probably congenital*  
*No further infection*



D 62327

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62327

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE (No. 514 N. Eutan St. ST.

REGISTERED No. C

WARD) 17

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## FULL NAME

Paul G. Mory(Residence in Baltimore: No. 514 N. Eutan St.St. 9 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX <u>male</u>	4-COLOR OR RACE, <u>white</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) <u>single</u>
6-DATE OF BIRTH, <u>Oct 4, 1888</u> (Month) (Day) (Year)		
7-AGE, <u>33</u> yrs. <u>5</u> mos. <u>8</u> ds. If LESS than 1 day, ... hrs. or ... min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). <u>Black</u>		
9-BIRTHPLACE, (State or Country), <u>Pa.</u>		
PARENTS.	10-NAME OF FATHER, <u>James H. Moore</u>	
	11-BIRTHPLACE OF FATHER (State or Country), <u>Pa.</u>	
	12-MAIDEN NAME OF MOTHER <u>Gunsallus</u>	
	13-BIRTHPLACE OF MOTHER (State or Country), <u>Pa.</u>	

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Anne E. Moore(Address) 514 N. Eutan

15-

Robert P. Harrison,

Filed 191

Registrar.

3 1922

Burial Permit Work

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 12, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest, au-inquest find that said deceased came to death  
(Inquest, autopsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute myocardial infarction  
(Duration) ... yrs. 2 mos. ... ds.CONTRIBUTORY  
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. P. Harrison, M. D.  
(Coroner.)March 12, 1922 (Address) 2802 E. Eutan St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Snow Shoe Pa

DATE OF BURIAL,

March 12, 1922

20-UNDERTAKER

W M Rounton

ADDRESS

230 N Greene

*Quick Review against death*  
*Toxemia*

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges,*

*peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septichæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

*Abortion, Hæmorrhage, Meningitis, Phlebitis, Cellulitis, Gangrene, Miscarriage, Pyæmia, Childbirth, Gastritis, Necrosis, Septicæmia, Convulsions, Erysipelas, Peritonitis, Tetanus.*

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to same.

D 62328

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *244 - Maryland* ST. *6* WARD)2-FULL NAME *James W. Cole*(Residence in Baltimore No. *244 Maryland*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE,

*Col.*5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)*Bahn*

6-DATE OF BIRTH,

*Oct 2**2**P*

7-AGE,

*6* yrs. *10* mos. *10* da.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Bahn*9-BIRTHPLACE,  
(State or Country),*Bahn*

10-NAME OF FATHER,

*James W. Cole*11-BIRTHPLACE OF FATHER  
(State or Country),*Bahn*

12-MAIDEN NAME OF MOTHER

*James Cole*13-BIRTHPLACE OF MOTHER  
(State or Country),*Bahn*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James Cole*(Address) *244 Maryland*

15-

MAR 14 1922

ROBERT R. KRAUTER,

101.

Burial Permit Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Mar 12*, 19*22*  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an.....  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said.....  
(Inquest, au-topsy or inquiry.) And that said deceased came to.....death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

*2 Broncho Pneumonia*  
(Duration).....yrs.....mos.....da.CONTRIBUTORY  
(Secondary)

(Duration).....yrs.....mos.....da.

(Signed) *J. R. ...* M. D.

(Coroner.)

5-12, 1922 (Address) *7 E. ...*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Laurel Cemetery* *Mar 14*, 19*22*

20-UNDERTAKER

ADDRESS

*Milton Davis 315 N. Eden St.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62329

D 62329

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1749 Mulliken St. ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1749 Mulliken St. St.; 6 yrs. 0 mos. 0 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE,

Caucasian

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

## 6-DATE OF BIRTH

September 17, 1890  
(Month) (Day) (Year)

## 7-AGE,

31 yrs. 0 mos. 0 ds.  
If LESS than 1 day, 0 hrs. or 0 min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE,

(State or Country),

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER

(State or Country),

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER

(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanche Patterson(Address) 1648 Mulliken St.

## 15-

MAR 14 1922 ROBERT R. KRAUTER,

Burial Permit 1144

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

March 12, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Feb 10, 1922 to Mar 12, 1922that I saw him alive on March 11, 1922and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(Duration) 2 yrs. 0 mos. 0 ds.CONTRIBUTORY La Grippe(Secondary) (Duration) 1 mos. 12 ds.(Signed) Richard B. Bessinger, M. D.Mar 12, 1922 (Address) 1514 E. Balto. St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Laurel Cemetery March 15, 1922

## 20-UNDERTAKER

## ADDRESS

Milton Davis 315 A Eden St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62330

## CERTIFICATE OF DEATH.

D 62330

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No

ST.,

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

ST.,

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male Chinese Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years

Months

Days

If LESS than  
1 day, ....hrs.  
or ....min.

52

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundry man

(b) General nature of industry, business, or establishment in which employed (or employer)

041

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

China

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

China

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

China

14

Informant  
(Address)Chin Yee John  
525 W Howard St

15

MAR 14 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1922

17

I HEREBY CERTIFY, That I attended deceased from  
March 6, 1922, to March 12, 1922  
that I last saw him alive on March 12, 1922  
and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH\* was as follows:

Myocardial Disease of the  
heart & Nephritis  
(duration) yrs. 8 mos. 21 ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Don't know

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

L

(Signed)

W. K. G. J. G. J. G.

M. D.

3/14/1922

(Address)

17 W. J. J. J. J.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Baltimore Cemetery

Mar 14, 22

20 UNDERTAKER

ADDRESS

John C. Mitchell 1701 W. J. J. J.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Chronic Interstitial  
nephritis.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62331

D 62331

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1150 Russell

ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Jane Elizabeth Watkins

(a) RESIDENCE. No.

1150 Russell

ST. WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Daniel Watkins

6 DATE OF BIRTH (month, day, and year)

March - 1884

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

88

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Quakerneck, Md  
Maryland

10 NAME OF FATHER

James Reese

11 BIRTHPLACE OF FATHER (city or town)

Quakerneck  
Maryland

(State or country)

12 MAIDEN NAME OF MOTHER

Elizabeth Bassick

13 BIRTHPLACE OF MOTHER (city or town)

Quakerneck  
Maryland

(State or country)

14

Informant (Address)

Agusta Davis  
1150 Russell St

15

Filed

MAR 14 1922

ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1922

17

HEREBY CERTIFY, That I attended deceased from

Feb 24 1922, to March 12 1922,

that I last saw her alive on March 12 1922,

and that death occurred, on the date stated above, at 10:35 p.m.

The CAUSE OF DEATH\* was as follows:

Sclerotic myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Hypostatic pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical signs

(Signed)

John E. J. Camper M. D.

19 (Address)

1400 Mount

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Auburn

DATE OF BURIAL

3-15 1922

20 UNDERTAKER

John W. Traden

ADDRESS 142

West St

D 62332

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62332

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1052 W Fayette St.

ST.

18

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Margaret F. Cadwell

## (a) RESIDENCE. NO.

1052 W Fayette St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

5 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

F

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Widowed

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Henry A. Cadwell

## 6 DATE OF BIRTH (month, day, and year)

March 7, 1884

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

78

6

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Homemaker

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Fallot Co. Md

## 10 NAME OF FATHER

Wm Cordiff Kadwell

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Fallot Co. Md

## 12 MAIDEN NAME OF MOTHER

Amie M. Leona

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Fallot Co. Md

## 14

## Informant (Address)

Charles Carroll Cadwell 1052 W. Fayette St.

## 15

MAR 14 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 13, 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

March 8, 1922, to March 13, 1922.

that I last saw her alive on March 13, 1922.

and that death occurred, on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH\* was as follows:

Arterio-sclerosis over

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. S. Jare M. D.

Address 720 W. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Easton Maryland

## DATE OF BURIAL

March 16, 1922

## 20 UNDERTAKER

George J. Smith

## ADDRESS

Fayette St.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No hemorrhage.*  
*No paralysis.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62333

62333

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 1032 S. Eutaw Street. St. 23 Ward)

Registered No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Walter S. Camphor. (C).

(Residence in Baltimore: No. 1032 S. Eutaw Street. St.; yrs. 1 mos. 7 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, Colored. 5-Single, Single. Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, February 6th, 1922. (Month) (Day) (Year)

7-AGE, 1 yrs. 7 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore Md.

10-NAME OF FATHER, Simon Camphor. (C).

11-BIRTHPLACE OF FATHER, Md. (State or Country), Dorchester Co.

12-MAIDEN NAME OF MOTHER, Ola B. Cooler. (C).

13-BIRTHPLACE OF MOTHER, (State or Country), Caroline Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Simon Camphor. (C) (father).

(Address) 1032 S. Eutaw Street.

MAR 14 1922

ROBERT R. KRAUTER

Burial Permit Clerk, Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 12th, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to death on the day stated above. (Inquest, autopsy or Inquiry.)

The CAUSE OF DEATH\* was as follows:

Cobar Pneumonia.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signature) E. H. Reinhardt, M. D. (Coroner.)

Mar. 14, 1922. (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

In all cases, 3/14/1922

20-UNDERTAKER, ADDRESS

R. Z. Parkman 649 N. Luz St.

D 62334  
2230

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62334  
44

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2427 Francis ST., 13 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Beili Altschul

## (a) RESIDENCE NO.

2427 Francis

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Intm.

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
41 — —

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Louis Rosenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Rachel Stein

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

N. Altschul  
2427 Francis St.

15

MAR 14 1922

ROBERT R. KRAUTER,

Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1922

17

I HEREBY CERTIFY, That I attended deceased from

June 8, 1922, to March 12, 1922,

that I last saw him alive on March 12, 1922,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of pyloric end of  
Stomach, with metastases  
to glands of pancreas

(duration) yrs. 10 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at 1132 S. Lombard St.

Did an operation precede death? yes Date of operation June 8, 1922

Was there an autopsy? no

What test confirmed diagnosis? Surgical Clinical

(Signed) R. E. Nicholson, M. D.

3/14, 1922 (Address) 2230 Cutaw Place.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Hebrew Haring Bur

3/14 1922

20 UNDERTAKER

ADDRESS 1121

Max Linsner

E. Balto

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62335

## CERTIFICATE OF DEATH.

90 D 62335

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

508K Glover

ST.,

WARD)

## 2-FULL NAME

Adam. Lyleh

(a) RESIDENCE NO.

508K Glover

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos.

ST.,

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Christina Lyleh

6 DATE OF BIRTH (month, day, and year)

Oct 18-1878

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

80

4

26

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Hoodler or

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired 10 yrs

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Conrad Lyleh

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Dora Lyleh

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mrs F. R. Weaver 508K Glover St

15

MAR 14 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1922

17

I HEREBY CERTIFY, That I attended deceased from Mar 9, 1922, to Mar 13, 1922, that I last saw him live on Mar 12, 1922, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic myocarditis

Estimated (duration)

5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Acute uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward J. Marx, M. D.

, 19 (Address) 821 N. Patt. Pk. Av.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Matthews Church

20 UNDERTAKER

J. Berwick &amp; Co

DATE OF BURIAL

Mar 15, 1922

ADDRESS

2008 Adams

From is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62336

## CERTIFICATE OF DEATH.

D 62336

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hosp*)ST.: *7*

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Katherine Selig*(a) RESIDENCE, No. *1313 E. Monument*

(Usual place of abode)

ST.: *40*

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *40* yrs. mos. ds.

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*F*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Single*6 DATE OF BIRTH (month, day, and year) *Jan 11 1891*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*71*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *Don't know*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Germany*12 MAIDEN NAME OF MOTHER *Don't know*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Germany*

14

Informant *Miss Gertrude Jacklein*  
(Address) *3035 North Ave*

15

MAR 14 1922

ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/12/22*

17

I HEREBY CERTIFY, That I attended deceased from

*Sunday 3/12*, 19 *22* to *3/12*, 19 *22*that I last saw her alive on *3/12*, 19 *22*and that death occurred, on the date stated above, at *6 P. m.*

The CAUSE OF DEATH\* was as follows:

*Broncho pneumonia*(duration) yrs. mos. ds. *11*CONTRIBUTORY (Secondary) *Cardiac Failure*(duration) yrs. mos. ds. *1*18 Where was disease contracted if not at place of death? *at home*Did an operation precede death? *—* Date of *—*Was there an autopsy? *yes*

What test confirmed diagnosis?

(Signed) *Dr. J. H. Gault*, M. D., 19 (Address) *Hebrew Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Beth Cemetery**Mar 15* 19 *22*

20 UNDERTAKER

ADDRESS

*J. Herwig & Co.**2008 E. Lexington*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62337

## CERTIFICATE OF DEATH.

100-8002  
62337

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105th Durham ST., 6 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Clarence E Madden

## (a) RESIDENCE NO.

105th Durham ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 3 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Dec 11-21.

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Balto

## 10 NAME OF FATHER

Richard Madden

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto

## 12 MAIDEN NAME OF MOTHER

Effie Lindo

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

## 14

Informant (Address)

Richard Madden  
105th Durham

## 15

MAR 14 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Mar 12 1922

## 17 I HEREBY CERTIFY, that I attended deceased from

Mar 6 1922 to Mar 12 1922that I last saw him live on Mar. 9 1922and that death occurred, on the date stated above, at 4 pm.

The CAUSE OF DEATH\* was as follows:

Cap Brouchet

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

G. C. Brouchet M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

Mount Carmel Cem  
J. K. K. & CoMar 14 1922  
2108 St. Anne

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior*

D 62338

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *5011 Beauregard St.* WARD) *27*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Evelyn May Parker*(Residence in Baltimore: No. *5011 Beauregard St.* St.; *0* yrs., *5* mos., *5* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Female*

## 4-COLOR OR RACE,

*Colored*5-SINGLE, *Single*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

*November 26<sup>th</sup> 1921*  
(Month) (Day) (Year)

## 7-AGE,

*5* yrs., *0* mos., *11* ds.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Domestic*(b) General nature of industry, business, or establishment in which employed (or employer) *Domestic*9-BIRTHPLACE,  
(State or Country),*Balto. City, Md*

## 10-NAME OF FATHER,

*Stockton B. Parker*11-BIRTHPLACE OF FATHER  
(State or Country),*Rockyville Md*

## 12-MAIDEN NAME OF MOTHER

*Clsie Graham*13-BIRTHPLACE OF MOTHER  
(State or Country),*Birkettville, Fred, Co. Md.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Clsie Parker (Mother)*(Address) *5011 Beauregard Ave*

## 15-

Filed

MAR 14 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*March 12 1922*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*March 2 1922* to *March 12 1922*that I saw her alive on *March 11 1922*and that death occurred, on the date stated above, at *m.*

The CAUSE OF DEATH\* was as follows:

*Brain pneumonia*(Duration) *9* yrs., *0* mos., *9* ds.

## CONTRIBUTORY

(Secondary)

*Ant. Card. Dilatate*  
(Duration) *9* yrs., *0* mos., *9* ds.(Signed) *Dr. Z. S. Smith**March 13 1922* (Address) *5011 Beauregard Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *5* yrs., *0* mos., *5* ds. In the State *5* yrs., *0* mos., *5* ds.Where was disease contracted, if not at place of death? *Same*Former or usual residence *Same*

## 19-PLACE OF BURIAL OR REMOVAL,

*Rockyville*

## DATE OF BURIAL,

*Mar. 14<sup>th</sup> 1922*

## 20-UNDERTAKER

## ADDRESS

*Jas. M. Skimmer 1625 E. Mad. St.*



# Primary broncho pneumonia

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

*lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

<i>Abortion,</i>	<i>Cellulitis,</i>	<i>Childbirth,</i>	<i>Convulsions,</i>
<i>Hæmorrhage,</i>	<i>Gastritis,</i>	<i>Erysipelas,</i>	<i>Meningitis,</i>
<i>Gangrene,</i>	<i>Miscarriage,</i>	<i>Necrosis,</i>	<i>Peritonitis,</i>
<i>Phlebitis,</i>	<i>Pyæmia,</i>	<i>Septicæmia,</i>	<i>Tetanus.</i>

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.

D 62339

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 D 62339

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2407 Fleet* ST., *1* WARD)2-FULL NAME *Kate Miller*(a) RESIDENCE NO. *2407 Fleet*

(Usual place of abode)

Length of residence in city or town where death occurred *1* yrs. *0* mos. *0* ds.

ST.,

WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of *John G. Miller* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *March 5, 1890*7 AGE Years *32* Months *0* Days *8* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto* (State or country) *M.d.*10 NAME OF FATHER *Louis Proetger*11 BIRTHPLACE OF FATHER (city or town) *Balto* (State or country) *M.d.*12 MAIDEN NAME OF MOTHER *Barrie Kuehner*13 BIRTHPLACE OF MOTHER (city or town) *Balto* (State or country) *M.d.*

14

Informant *John G. Miller* (Address) *2407 Fleet St.*

15

MAR 14 1922

ROBERT H. KRAUTER,

Burial Permit Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 13 1922*

17

I HEREBY CERTIFY, That I attended deceased from *7 Mar*, 1922, to *12 Mar*, 1922, that I last saw her alive on *12 Mar*, 1922, and that death occurred, on the date stated above, at *12 45 A. m.*

The CAUSE OF DEATH\* was as follows:

*Charles Velalaban*CONTRIBUTORY (Secondary) *Chronic Endocarditis and Aortic Insufficiency* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Murmurs* (Signed) *W. H. Mohr*, M. D., 19 (Address) *3018 Ellwood Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Baltimore Cemetery* *Nov 15 1922*

20 UNDERTAKER

ADDRESS

*A. Vander & Sons**710 Flat St.*

FROM IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

154289  
D 62340

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO. JOHNS HOPKINS HOSPITAL ST. 76 WARD)

## 2-FULL NAME

## (a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced (write the word)

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

## 14

Informant  
(Address)

## 15

File

MAR 14 1922

ROBERT R. KRAUTER,

Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

## 17

I HEREBY CERTIFY, That I attended deceased from

March 6, 1922 to March 11, 1922

that I last saw her alive on March 11, 1922

and that death occurred, on the date stated above, at 6:45 P. M.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 1 1/2 ds.

CONTRIBUTORY arteriosclerosis & hypertension  
(Secondary) hypertension  
(duration) 2 yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Autopsy(Signed) Francis R. Dicandia, M. D.12, 1922 Address Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

1810 E. Butler St.

D 62341

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62341

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 129 N. Milton Ave. ST., 6 WARD)

## 2-FULL NAME

Gold Villiman

(a) RESIDENCE NO. 129 N. Milton Ave. ST.,

WARD

(Usual place of abode)  
Length of residence in city or town where death occurred 30 yrs.

mos.

ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Margaret Villiman

6 DATE OF BIRTH (month, day, and year) March 12-1869

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

52 11 15

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

black 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Long Island New York

10 NAME OF FATHER

Augustus Villiman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Long Island N. Y.

12 MAIDEN NAME OF MOTHER

Katherine Johnston

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Long Island N. Y.

14

Informant (Address)

Margaret Villiman 129 N. Milton Ave.

15

ROBERT H. KRAUTER,

MAR 14 1922

Surgeon General Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 12 1922

17 I HEREBY CERTIFY, That I attended deceased from on March 12, 1922, to

that I last saw him alive on March 12, 1922,

and that death occurred, on the date stated above, at 8:35 P.M.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) Arterio-Sclerosis (duration) 14 hours

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Mar 14, 1922 (Address) 1810 E. Baltimore St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Baltimore Cemetery

Mar 15 1922 ADDRESS

20 UNDERTAKER

H. Sandus &amp; Sons

1710 Flat St.



D 62342

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1940 62342

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 313 Spring St. 3 Ward)

## 2-FULL NAME

(Residence in Baltimore: No. 313 S. Calver St. yrs. mos. ds.)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL

## 3-SEX

F.

## 4-COLOR OR RACE

C

5-Single,  
Married,  
Widowed,  
or Divorced,  
(Write the word.)

## 6-DATE OF BIRTH

unknown 1.  
(Month) (Day) (Year)

## 7-AGE

32

yrs. mos. ds.

If LESS than 1 day

hrs. or min.

## 8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

unknown

9-BIRTHPLACE,  
(State or Country).

Maryland

## 10-NAME OF FATHER

unknown

11-BIRTHPLACE OF FATHER,  
(State or Country)

unknown

## 12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER,  
(State or Country)

unknown

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

M. Brown

(Address)

108 N. Montg.

## 15-

Filed

APR 14 1940

Registrar

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

Mar. 12 1940  
(Month) (Day) (Year)

## 17-

I HEREBY CERTIFY, That the body of the

remains described above, held an

(Inquest, autopsy or inquiry.)

Thereon and from the evidence obtained by said

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH was as follows:

Homicide

Assault &amp; Battery

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) M. D.

(Address) 1736 Bay

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Michaels ma July 14 1940

20-UNDERTAKER, ADDRESS

J. L. Brownson 108 N. Montg.

*ac Del Heart  
Kicked & struck with fist*

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges,*

*peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

*Abortion, Hemorrhage, Meningitis, Phlebitis, Cellulitis, Gangrene, Miscarriage, Pyæmia, Childbirth, Gastritis, Necrosis, Septicæmia, Convulsions, Erysipelas, Peritonitis, Tetanus.*

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (if induced), whether death is directly or indirectly due to same.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62343

62343

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

WARD)

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan. 29, 1921

7 AGE

Years

Months

Days

41 LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto., Md.

10 NAME OF FATHER

Andrew J. Byrne

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Bridget E. Tuma

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Andrew J. Byrne  
823 E. Fort Ave.

15

Filed

MAR 14 1922

Registrar

G. G.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 12, 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 20, 1922, to March 12, 1922, that I last saw him alive on March 12, 1922.

And that death occurred, on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH\* was as follows:

Bilateral Broncho pneumonia

CONTRIBUTORY (Secondary) Pulmonary edema (duration) yrs. mos. 21 ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) J. H. O. M. D.

19 (Address) 107 E. West St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cathedral Cem.

UNDERTAKER

Margaret S. Flynn

DATE OF BURIAL

Mar 14, 1922

ADDRESS

1422 Highland St.

D 62344

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62344

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 530 Dolphin St. ST.: 17 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE

No.

530 Dolphin St.

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov. 1870

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

52

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Wm Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Wm C Lee 530 Dolphin St.

15

Filed

MAR 14 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11<sup>th</sup> 1922

17

I HEREBY CERTIFY. That I attended deceased from

March 6<sup>th</sup>, 1922, to March 11<sup>th</sup>, 1922,that I last saw her alive on March 11<sup>th</sup>, 1922,

and that death occurred, on the date stated above, at 7:15 P. M.

The CAUSE OF DEATH\* was as follows:

Endocarditis Chronic

Personal knowledge

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Broken Compensation

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs &amp; Symptoms

(Signed) W. Garrison Marks M. D.

3/13, 1922 (Address) 901 North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lanier Cemetery

Mar 15 1922

20 UNDERTAKER

ADDRESS

George H. Holland

1631 Oriole Hillpark



## HEALTH DEPARTMENT—CITY OF BALTIMORE

62345

62345

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 134 W. West ST. 23 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Annie Hackett

## (a) RESIDENCE. NO.

134 W. West

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Nov. 14 1889

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

33

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

General

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore City Md

## 10 NAME OF FATHER

Henry Spence

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Mary L. Boas

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

## 14

Informant (Address)

Bessie Hackett 134 W. West St

## 15

Filed

19

MAR 14 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

3/11/22

## 17

I HEREBY CERTIFY, That deceased from

Oct 18/21 to Mar 11/22 that I last saw him alive on Mar 10/22and that death occurred, on the date stated above, at 11:41 P.M.

The CAUSE OF DEATH\* was as follows:

Phthisis Pulmonalis

## CONTRIBUTORY (Secondary)

recurrent

## 18 Where was disease contracted if not at place of death?

noneDid an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

3/14/22

(Address)

908 Ashland St

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Mount Vernon3/14/22

## 20 UNDERTAKER

## ADDRESS

Samuel H. Hensley517 N. E. St.

D 62346 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62346

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE (No. *University Hospital* ST. *19* WARD)2-FULL NAME *Richard E. Stewart*(Residence in Baltimore: No. *400 N. Filmore*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*Male*

4-COLOR OR RACE,

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

*Unknown, 1877*  
(Month) (Day) (Year)

7-AGE,

*45*

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Laborer in  
Lst. market*

9-BIRTHPLACE, (State or Country),

*Baltimore Md*

10-NAME OF FATHER,

*Thomas Stewart*

11-BIRTHPLACE OF FATHER (State or Country),

*Md*

12-MAIDEN NAME OF MOTHER

*Frances Cook*

13-BIRTHPLACE OF MOTHER (State or Country),

*Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frances Maffield*(Address) *400 N. Filmore*

15-

Filed....., 191.....

MAR 14 1922

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*March 11, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, or

find that said deceased came to his death (Inquest, or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis*  
(Duration) *Don't know* yrs. mos. ds.CONTRIBUTORY (Secondary) *Don't know*

(Duration) yrs. mos. ds.

(Signed) *W. H. Garrison* M. D.3-13, 1912 (Address) *117 N. Seneca*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Ambrose**3/15, 1922*

20-UNDERTAKER

ADDRESS

*Samuel T. Hensley**378 N. Bidart St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62347

## CERTIFICATE OF DEATH.

REGISTERED NO.

45 D 62347

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1537 N Appleton St. 45 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Theresa J Hummel

(a) RESIDENCE. No. 1537 N Appleton ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Geo H Hummel

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 70

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Phila. Pa

10 NAME OF FATHER

James MacAraan

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Scotland

12 MAIDEN NAME OF MOTHER

Ellen Daugherty

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

George H Hummel Jr 1537 N Appleton St. C

15

Filed

19

MAR 14 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1922, to Mar 12, 1922, that I last saw him alive on Mar 11, 1922.

and that death occurred, on the date stated above, at 4 4 m.

The CAUSE OF DEATH\* was as follows:

Pneumonia of diaphragm

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

Pulm Engstrom

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan - 22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas E. Blos M. D.

19 (Address) 20 N. B. Blos St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

March 10 1922

20 UNDERTAKER

ADDRESS

Merrill Jackson Son 1827 W North

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62348

## CERTIFICATE OF DEATH.

001  
161 D 62348

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland General Hospital* 19 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*James Patrick Scott*

## (a) RESIDENCE NO.

*1628 Hollins St*

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*single*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Mar. 13, 1922*

## 7 AGE

Years

Months

Days

If LESS than 1 day, 5 hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Baltimore Maryland*

## 10 NAME OF FATHER

*Verden J. Scott*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*New York*

## 12 MAIDEN NAME OF MOTHER

*Almira S. Kirhan*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore Maryland*

## 14

Informant (Address)

*Mr. Almira S. Scott 1628 Hollins St.*

9141922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 13 1922*

## 17

I HEREBY CERTIFY That I attended deceased from

*Mar 13 1922 to Mar 13 1922*that I last saw him alive on *Mar 13 1922*and that death occurred, on the date stated above, at *1 P.m.*

The CAUSE OF DEATH\* was as follows:

*Prematurity*

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *1628 Hollins St*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical Exam*(Signed) *Stanley W. Matthews, M.D.*19 (Address) *Maryland General Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

*J. Patrick Clements*

## ADDRESS

*13-14 1922**L. A. Moran**C. B. Ball*

See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62349

## CERTIFICATE OF DEATH.

161 D 62349

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3004 Brighton

ST. 16 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (not named) (male child) Infant Winters

(a) RESIDENCE. No. 3004 Brighton

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-14-22

7 AGE Years Months Days If LESS than 1 day, — hrs. or 5 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Ind. (State or country)

10 NAME OF FATHER John Henry Winters

11 BIRTHPLACE OF FATHER (city or town) Balto Ind. (State or country)

12 MAIDEN NAME OF MOTHER Margaret F. Tappan

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Ind. (State or country)

14 Informant John Henry Winters (Address) 3004 Brighton St.

15 File MAR 14 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-14-1922

17 I HEREBY CERTIFY, That I attended deceased from 3-14-1922, to 3-14-1922,

that I last saw him alive on 3-14-1922, and that death occurred, on the date stated above, at 6:03 a.m.

The CAUSE OF DEATH\* was as follows:

Intra-cranial hemorrhage.

(duration) — yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? irregular pupils

(Signed) Chester Riland, M. D.

2-14-1922 (Address) 2632 Edmondson Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral Ceme 3/14/22

20 UNDERTAKER ADDRESS

J. J. Corran, Inc 901 Hollins

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62350

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 743 S Luzerne ST., 1 WARD)

## 2. FULL NAME

Ferdinand Koch

## (a) RESIDENCE NO.

(Usual place of abode)

743 S Luzerne ST.,

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX. Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofthe late Mary Koch6 DATE OF BIRTH (month, day, and year) Aug 22 18577 AGE Years 65 Months 6 Days 20 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Poland

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant  
(Address)Mrs. Mary Wessha  
2144 Dundas St

15

ROBERT R. KRAUTER,

Registrar  
Burial Permit Clerk

MAR 14 1922

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 192217 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1922, to March 12, 1922.that I last saw him alive on March 12, 1922.and that death occurred, on the date stated above, at 4:45 a.m.

The CAUSE OF DEATH\* was as follows:

Arteriosclerosis(duration) UnknownCONTRIBUTORY  
(Secondary)Astma ca 4 weeks

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? noWas there an autopsy? no

What test confirmed diagnosis?

(Signed) J. J. Janney M. D.3/13, 1922 (Address) 2431 East Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy RosaryMarch 15 1922

20 UNDERTAKER

ADDRESS

John A. Weber 1803 Bank

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Primary arterio sclerosis.*  
*No hemorrhage.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62351

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

University Hospital

CITY OF BALTIMORE: (No.

Lombard &amp; Greene

ST.,

WARD)

2-FULL NAME

Baby Woodyard

(a) RESIDENCE NO.

New Windsor, Md

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 25 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Mr. Horney

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Martha Woodyard 3/13, 1922 (Address)

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Univ. Hosp. Records

15

MAR 14 1922

ROBERT A. KRAUTER Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1922

17

HEREBY CERTIFY, That I attended deceased from July 25, 1922, to March 13, 1922, that I last saw him alive on March 13, 1922, and that death occurred, on the date stated above, at 12:5 A. M. The CAUSE OF DEATH\* was as follows:

General Septicemia.

(duration) yrs. mos. ds. 45

CONTRIBUTORY Instrumental delivery (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Morris Reese M. D.  
University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

MAR 14 1922

20 UNDERTAKER

ADDRESS

Commissioner Health



D 62352 HEALTH DEPARTMENT—CITY OF BALTIMORE 62352

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3643 Lehigh

ST.: 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Laopold B. Stoll

## (a) RESIDENCE

No. 3643 Lehigh

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

male

## 4 COLOR OR RACE

white

## 5 Single, Married, Widowed, or Divorced (write the word)

single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Oct. 7, 1864

## 7 AGE

Years

57

Months

5

Days

6

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Florist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

## 10 NAME OF FATHER

Adolph Stoll

## PARENTS

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Mary L. Heller

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

## 14

Informant (Address)

Joseph Stoll 4795 Reisterstown Road

## 15

Robert P. Clark

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Mar 13 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Nov 1921, to Mar 13, 1922,

that I last saw him alive on 7<sup>th</sup> day, Mar 13, 1922,and that death occurred, on the date stated above, at 2<sup>nd</sup> ward.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Left side of Pharynx (Starting in Left Tonsil

(duration) yrs. 20 mos. ds.

CONTRIBUTORY (Secondary)

Hemorrhage of Left External Carotid artery or Branching of Internal

(duration) hrs. 1 ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. P. Schamel M. D.

, 19 (Address) 102-N. Hillton St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral

## DATE OF BURIAL

March 16, 1922

## 20 UNDERTAKER

G. W. Dill

## ADDRESS

319 Fredk. Ave.

4 1922

Burial Record Clerk

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *24* WARD)2-FULL NAME *William Sullivan*(a) RESIDENCE. No. *1741 Jackson* ST. *27* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *4* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Grace Sullivan*6 DATE OF BIRTH (month, day, and year) *April 4, 1873*7 AGE Years *48* Months *11* Days *9* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer - 084*(b) General nature of industry, business, or establishment in which employed (or employer) *Tinner*(c) Name of employer *B. & O. R. R.*9 BIRTHPLACE (city or town) (State or country) *Ma.*10 NAME OF FATHER *Woodson Sullivan*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ma.*12 MAIDEN NAME OF MOTHER *Aida Cromer*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ma.*14 Informant *Grace Sullivan* (Address) *1741 Jackson St.*15 FIND *MAR 14 1922* Registrar *J. E. Keim*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 13, 1922*17 I HEREBY CERTIFY, That I attended deceased from *March 10, 1922*, to *March 13, 1922*, that I last saw him alive on *March 13, 1922* and that death occurred, on the date stated above, at *8:10 P. M.*

The CAUSE OF DEATH\* was as follows:

*Bilateral confluent bronchial pneumonia.*(duration) yrs. mos. *6* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *Autopsy* (Signed) *J. E. Keim* M. D.3/13, 1922 Address *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Burrisberg Co. March 15, 1922*

20 UNDERTAKER ADDRESS

*Wm. J. Lane 14th & 6th*



D 62355 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62355

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2000 Plymouth Ave 3 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Hells

(a) RESIDENCE No. 2000 Plymouth Ave WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Violetta E. Hells

6 DATE OF BIRTH (month, day, and year) Oct. 20, 1860

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

61 4 23

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Va

## 10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

## 14

Informant (Address)

John J. Hells  
Oakland Carroll Co

## 15

Filed

19

Registrar

41922 Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 1, 1922, to March 13, 1922,

that I last saw him alive on March 13, 1922,

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH\* was as follows:

Complete Pericarditis

CONTRIBUTORY (duration) yrs. mos. ds. 1 yr. 1 mo. 1 da.  
Pneumonia

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? Date of

No

Was there an autopsy?

No

What test confirmed diagnosis?

Physician's report

Signed: E. J. Hells M. D.

14, 1922 Address: 3105 Jackson St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Oakland Carroll Co March 16, 1922

20 UNDERTAKER ADDRESS

Chenoweth &amp; Son Chestnut Ave



REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Chronic interstitial  
nephritis. Cerebral  
hemorrhage.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62356

## CERTIFICATE OF DEATH.

181-1001  
D 62356  
REGISTERED No. C

## PLACE OF DEATH

CITY OF BALTIMORE (No. *2716* *St. Bernard St.* WARD *12*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## FULL NAME

*Mary Eumor*(Residence in Baltimore: No. *2716* *Bernard St.* St., yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*F*

## 4-COLOR OR RACE,

*W*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*

## 6-DATE OF BIRTH

*June 12*, 18*57*  
(Month) (Day) (Year)

## 7-AGE,

*64* *9* ds.

If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*Mill Operator*

## 9-BIRTHPLACE, (State or Country),

*M.D.*

## 10-NAME OF FATHER,

*John Clark*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Ireland*

## 12-MAIDEN NAME OF MOTHER

*Sophia Murphy*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Va*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*George M. Smith*

(Address)

*2205 Hazel Ave*

## 15-

Robert P. Harrison,

191.

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*March 12*, 19*22*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry)thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.)*inquest* find that said deceased came to *his* death on the *day* stated above.

The CAUSE OF DEATH\* was as follows:

*Asphyxiation by gas (accidental)*(Duration) .... yrs. .... mos. .... ds.  
(*accidental*) *Leaky hose.*  
(CONTRIBUTORY (Secondary))(Signed) *J. T. Harrison* M. D.  
(Coroner)(Address) *2802 E. ...*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place *2716 Bernard St.* In the of death .... yrs. .... mos. .... ds. State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? ....

*2719 Bernard St.*Former or usual residence *same*

## 19-PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL,

*Mar 14 1922*

## 20-UNDERTAKER

## ADDRESS

*Chenoweth & Son Chestnut*

D 62357 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62357

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2914 Bernard ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME William D. Sherman

(a) RESIDENCE. No. 2914 Bernard ST., WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 11

mos. 13

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) April 16 1921

7 AGE

Years

Months 11

Days 13

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) MD

10 NAME OF FATHER Wm. Sherman

11 BIRTHPLACE OF FATHER (city or town) (State or country) MD

12 MAIDEN NAME OF MOTHER Emma Berwanger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) MD

14

In (Address) 2914 Bernard St.

APR 4 1922

Robert P. Harrison,

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 6 1922, to March 15 1922.

that I last saw him alive on March 13 1922.

and that death occurred, on the date stated above, at 7:10 p.m.

The CAUSE OF DEATH\* was as follows:

Primary Broncho Pneumonia (duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Fair

M. D.

3/18/22 (Address) 126 W. 14th

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Greenmount Carroll Cemetery 1922

20 UNDERTAKER

ADDRESS

Chenaweth &amp; Son Chestnut

D 62358

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62358

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE: (No. 425 S. Parish ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosaline A. Batterill(a) RESIDENCE. NO. 425 S. Parish ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofGuy R. Batterill6 DATE OF BIRTH (month, day, and year) Dec. 18, 19077 AGE Years Months Days If LESS than 1 day, hrs. or min.  
18 2 24 —

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.  
(State or country)10 NAME OF FATHER James Sager11 BIRTHPLACE OF FATHER (city or town) Balto. Md.  
(State or country)12 MAIDEN NAME OF MOTHER Charlotte S. Sier13 BIRTHPLACE OF MOTHER (city or town) Md.  
(State or country)14 Informant James Sager  
(Address) 425 S. Parish St.15 Filed Robert P. Harrison Registrar

R 14 1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13, 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1922, to March 13, 1922,that I last saw him alive on March 12, 1922,and that death occurred, on the date stated above, at 8.30 m.

The CAUSE OF DEATH\* was as follows:

Acute Endocarditis(duration) yrs. mos. 16 ds.CONTRIBUTORY Ac. Rheumatic fever  
(Secondary) (duration) yrs. mos. 19 ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? NO Date ofWas there an autopsy? NOWhat test confirmed diagnosis? Clinical  
(Signed) J. T. Hennessy, M. D.1922 Address 2802 Edmonson Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

LOUDON PARK CEM 3/16 1922

20 UNDERTAKER ADDRESS

ROBERT BROOKS & SON CALHOUN HOLLINS



D 62359

62359

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *20* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs Anna V Jones*(a) RESIDENCE. NO. *2564 W Balto St* ST. \_\_\_\_\_ WARD. \_\_\_\_\_

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *45* yrs. *5* mos. *4* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Harry Jones*6 DATE OF BIRTH (month, day, and year) *1876 Aug 18*

7 AGE

*45*

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*5 24*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

*637*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Maryland*

10 NAME OF FATHER

*Mr Turner*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Maryland*

12 MAIDEN NAME OF MOTHER

*Mary Shanks*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Maryland*

14

Informant (Address)

*Hospital records*

15

Filed

*4 1922*

Robert P. Harrison,

Registrar

Burial Permit Clerk:

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 12* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar, 4th*, 19 *22*, to *Mar 12*, 19 *22*,that I last saw him alive on *3/12*, 19 *22*,and that death occurred, on the date stated above, at *5:45 P.* m.

The CAUSE OF DEATH\* was as follows:

*Epidemic nephritis*(duration) yrs. mos. *14* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *Autopsy & clinical findings*(Signed) *L. H. Calkins*, M. D., 19 (Address) *Univ Hospital*

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*WESTERN CEMETRY**MAR 16* 19 *22*

20 UNDERTAKER

*ROBERT BROOKS & SON*

ADDRESS

*CALHOUN*  
*HOLLINS*

D 62360

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62360

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. *509 N. Milton Ave* ST. *7* WARD)2-FULL NAME *Harriet Thomas*(Residence in Baltimore: No. *509 N. Milton Ave* St.; yrs., mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Widowed*  
(Write the word)6-DATE OF BIRTH, *June 15, 1840*

(Month)

(Day)

(Year)

7-AGE *81* yrs. *8* mos. *27* ds.

If LESS than 1 day, ... hrs. or ... min.

## 8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
- at home*
- 
- (b) General nature of industry, business, or establishment in which employed (or employer).
- 000*

9-BIRTHPLACE, *England*

(State or Country)

10-NAME OF FATHER, *Henry Phipps*11-BIRTHPLACE OF FATHER *England*

(State or Country)

12-MAIDEN NAME OF MOTHER *Not known*13-BIRTHPLACE OF MOTHER *Not known*

(State or Country)

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Melton Thomas*(Address) *509 N. Milton Ave*

## 15-

*Robert P. Harrison,*

Filed

191

1922

Birtel Permit Clerk.

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 14, 1972*

(Month)

(Day)

(Year)

## 17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Pulmonary embolism*  
*Cause unknown.*

(Duration) ... yrs. ... mos. ... ds.

## CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Robert P. Harrison* M. D.

(Coroner)

3-18, 101 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, *Frostburg* DATE OF BURIAL, *May 17, 1972*20-UNDERTAKER *Fisk & Fisk*ADDRESS *1737 Eager*

D 62361

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Volunteers of Am. Hosp.

REGISTERED NO.

CITY OF BALTIMORE: (No.

418 W. Lexington ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Selma D. Haefter St.

(a) RESIDENCE. NO.

Ridge Ave - Balto. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 21, 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Hom.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Curt Haefter

11 BIRTHPLACE OF FATHER (city or town)

Camden

(State or country)

N. J.

12 MAIDEN NAME OF MOTHER

Catherine McLaughlin

13 BIRTHPLACE OF MOTHER (city or town)

Pa

(State or country)

14

Informant

(Address)

Curt Haefter

Ridge Ave. P. O. Box

15

Filed

19

4 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-13-1922

17

I HEREBY CERTIFY, That I attended deceased from

3-12-1922, to 3-13-1922,

that I last saw her alive on 3-13-1922,

and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH\* was as follows:

Second degree burn.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY

(Secondary)

Broncho pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Ridge Ave - Md

Did an operation precede death? 2nd Date of

Was there an autopsy? 2nd

What test confirmed diagnosis?

Clinical

(Signed) J. L. Fayman, M. D.

19 (Address) 418 W. Lexington

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Barrwood Cemetery

Mar 14 1922

20 UNDERTAKER

ADDRESS

Harry H. Witzel

15316 Lomb

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Mother prepared a pan of hot water for the baby & placed it on the floor. While mother was in another room after cold water the 4 yr. old brother knocked the baby into the hot water, thus scalding the baby.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62362

## CERTIFICATE OF DEATH.

91-002 D 62362

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1428 Madison Ave. ST., 14 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Caroline Peters Gale*

(a) RESIDENCE No. 1428 Madison Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*

6a If married, widowed, or divorced

(or) WIFE of

*Richard W. Gale*6 DATE OF BIRTH (month, day, and year) *1838*7 AGE Years *84* Months *-* Days *-* If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*New York*10 NAME OF FATHER *Wm. Peters*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Mass*12 MAIDEN NAME OF MOTHER *Carolina Fick*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Nova Scotia*

14

Informant *Miss Gertrude Gale*  
(Address) *1428 Madison Ave.*

1922

19

Registrar

Via Penn R.R. to Mrs. Gertrude Gale

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 14 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar 14 1922* to *Mar 14 1922*that I last saw him alive on *Mar 14 1922*and that death occurred, on the date stated above, at *12 noon*

The CAUSE OF DEATH\* was as follows:

*arterio Sclerosis*(duration) *7* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical Exam*(Signed) *Wm. H. Jackson* M. D.3/14, 1922 (Address) *Maple Ave. Balduin Rd*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

*Peekskill, N.Y. Mar. 15, 1922*

20 UNDERTAKER

ADDRESS

*Cumcock 502 E. Martha St.*

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Primary arterio sclerosis*  
*No hemorrhage.*

D 62363

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74 D 62363

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *Mount Hope Retreat* ST. *28* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *John Henry Rinefleisch*(a) RESIDENCE. NO. *Mount Hope Retreat* ST. *28* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *1* yrs. *8* mos. *0* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced  
HUSBAND of *Mrs Rinefleisch*  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Not Known*7 AGE Years *63* Months *0* Days *0* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Packer*(b) General nature of industry, business, or establishment in which employed (or employer) *Packing House*

(c) Name of employer

9 BIRTHPLACE (city or town) *Not Known*  
(State or country) *Germany*10 NAME OF FATHER *Henry Rinefleisch* (2)11 BIRTHPLACE OF FATHER (city or town) *Germany*  
(State or country)12 MAIDEN NAME OF MOTHER *Annie* (2)12 BIRTHPLACE OF MOTHER (city or town) *Germany*  
(State or country)11 Informant *Records of Mount Hope Retreat*  
(Address) *Mount Hope Retreat*15 Filed *Robert F. Harrison,*

Registrar

41922 Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 14* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *July 2 3rd*, 19 *20*, to *March 14*, 19 *22*, that I last saw him alive on *March 13*, 19 *22*.and that death occurred, on the date stated above, at *3.30 a.* m.  
The CAUSE OF DEATH\* was as follows:*Paralysis - R. Hemiplegia**abt* (duration) *0* yrs. *1* mos. *0* ds.CONTRIBUTORY *Dementia Senile*  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
If not at place of death? *Baltimore*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Frank Flannery* M. D.19 (Address) *Mount Hope Retreat*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Mount Hope Retreat* *March 17* 19 *22*

20 UNDERTAKER ADDRESS

*Wm Cook 505 E North*

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Apoplectic*



## HEALTH DEPARTMENT--CITY OF BALTIMORE

D 62364

## CERTIFICATE OF DEATH

10 D 62364  
REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE: (No.

2110 E Lombard St.

ST.

WARD

(If death occurred in  
a hospital or institution,  
give its NAME instead of  
street and number and  
fill out No. 18.)

2-FULL NAME

Joseph P. Burkhard

(Residence in Baltimore: No.

2110 E Lombard St

St.; 6 yrs. 5 mos. 15 ds.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

white

5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

Single

6-DATE OF BIRTH

September 28,

(Month)

1915

(Day)

(Year)

7-AGE

6

yrs.

5

mos.

15

ds.

or

min.?

If LESS than  
1 day, hrs.

8-OCCUPATION

(a) Trade, profession or  
particular kind of work  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Schoolboy

9-BIRTHPLACE  
(State or country)

Baltimore

10-NAME OF  
FATHER

Anthony Burkhard

11-BIRTHPLACE  
OF FATHER  
(State or country)

Baltimore

12-MAIDEN NAME  
OF MOTHER

Emma E. Kiatz

13-BIRTHPLACE  
OF MOTHER  
(State or country)

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Anthony Burkhardt

(Address)

2110 E Lombard

15-

42322

Robert P. Harrison,

191

Burial Permit Clerk

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

March

13th

1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from  
Feb 24th, 1922, to, March 13, 1922,

that I saw him alive on March 13, 1922,

and that death occurred, on the date stated above, at 6:15 p.m.

The CAUSE OF DEATH\* was as follows:

Diphtheria  
Duration Feb 24 to March 8Contributory (SECONDARY) Puncture of Heart  
March 9 to March 13(Signed) H. J. Jackson M. D.  
March 14, 1922 [Address] 119 N. Miller\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,  
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL.18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS]

At place of death... yrs... mos... ds. In the State... yrs... mos... ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt Carmel Mar 16

1922

20-UNDERTAKER

ADDRESS

Wm Cook 505 E North Ave

D 62365

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62365

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *430 E 21<sup>st</sup>* ST. *12* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

*Clara L Goshin*(a) RESIDENCE NO. *430 E 21*

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred *1 1/2* yrs. mos. ds.How long in U. S., if of foreign birth *Life* mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Lerrin W. Goshin*6 DATE OF BIRTH (month, day, and year) *July 9, 1853*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*68 8*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*At home*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Home*

(c) Name of employer

9 BIRTHPLACE (city or town) *Dorchester, Mass.*  
(State or country)10 NAME OF FATHER *Isaac B. Gray*11 BIRTHPLACE OF FATHER (city or town) *Ireland*  
(State or country)12 MAIDEN NAME OF MOTHER *Barbara Passafium*13 BIRTHPLACE OF MOTHER (city or town) *Dorchester, Mass.*  
(State or country)

14

Informant  
(Address) *Lerrin W. Goshin*  
*430 E 21<sup>st</sup> St.**4 1922*

Robert E. Harrison,

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 19, 1922*17 I HEREBY CERTIFY, That I attended deceased from *July 15, 1922* to *March 12, 1922*,  
that I last saw him alive on *March 12, 1922*,  
and that death occurred, on the date stated above, at *6 a* m.

The CAUSE OF DEATH\* was as follows:

*Aneurysm of Aorta.*CONTRIBUTORY  
(Secondary)(duration) *3* yrs. mos. ds.(duration) *3* yrs. 1 mos. ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *No*(Signed) *Hugh Foreyhe*, M. D.19 (Address) *424 E. North Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

*Cambridge, Mass. March 15, 1922*  
*William Beck 501 E. North Ave.*

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

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**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Phy. does not think  
infective in origin.*

D 62366

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62366

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

Municipal Hospital, Bay View

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.: 15 WARD)

2-FULL NAME

Richard Steeks

(a) RESIDENCE. NO.

2122 Ridgewood Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

32 yrs. mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed,  
or Divorced (write the word)

M

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1888

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

32

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Labor

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

MD

10 NAME OF FATHER

Chas Steeks

PARENTS

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

D.C.

12 MAIDEN NAME OF MOTHER

Mary Burke

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

MD

14

Informant  
(Address)

Corp. Records

15

Filed

14 1922

Robert P. Harrison, Registrar

Burial. Parents Church

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3-14-1922

17

I HEREBY CERTIFY, That I attended deceased from

2-7-1922, to 3-14-1922

that I last saw him live on 3-14-1922

and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH\* was as follows:

Atrophic Cirrhosis

gallbladder (duration) yrs. 3 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde Monroe, M. D.

\*State the Disease Causing Death, or in death from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cem. Mar 17 1922

20 UNDERTAKER

ADDRESS

Crematorium 502 E. North St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62367

D 62367

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2502 Shirley Ave. S. 15 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2502 Shirley Ave.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 63 mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male  
4-COLOR OR RACE, White  
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed6-DATE OF BIRTH, June 18, 1841  
(Month) (Day) (Year)7-AGE, 80 yrs. 8 mos. 25 ds.  
If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work... Retired  
(b) General nature of industry, business, or establishment in which employed (or employer)... Restaurant Proprietor

9-BIRTHPLACE, (State or Country), Germany

10-NAME OF FATHER, Samuel A. Bauersfeld

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant, Mrs. David H. Whiteley)

(Address, 2502 Shirley Ave.)

15- Robert P. Harrison,

Filed 4/19/22 191. Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 13, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, that I took charge of the remains described above, held on Jan 13, 1922  
(Inquest, autopsy, or inquiry.)  
thereon and from the evidence obtained by me, and that said deceased came to death on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
Heart disease(Duration) ... yrs. ... mos. ... ds.  
CONTRIBUTORY (Secondary) ...  
(Signed) J. H. Harrison, M. D.  
(Cor. 5632 Ashland Ave.)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).  
At place In the  
of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.  
Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto. Cemetery DATE OF BURIAL, Nov. 15, 1922

20-UNDERTAKER, Wm. C. Black 927 Broadway ADDRESS

D 62368

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62368

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2931 E. Monument

ST.: 7 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Ellen C. Wales

(a) RESIDENCE. No. 2931 E. Monument

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of Wesley Wales

6 DATE OF BIRTH (month, day, and year) May 14, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	9	29	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Maryland

10 NAME OF FATHER Levi Robb

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

England

12 MAIDEN NAME OF MOTHER Emeline Everest

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Maryland

14

Informant Ava Robb

(Address) 2931 E. Monument St.

15

Robert P. Harrison,

Registrar

4 1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/13 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 15 1922, to Mar 13 1922,

that I last saw her alive on Mar 13, 1922.

and that death occurred, on the date stated above, at 11:30 A. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. E. Balt. St. M. D.

(Address) 311 E. 13

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Carmel Cemetery

March 16 1922

20 UNDERTAKER

ADDRESS

Wm. C. Plack 927 N. Broadway

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62369

D 62369

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 614 W. Baltimore St. Ward 90)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carmelo Carmatella(Residence in Baltimore: No. 614 W. Baltimore St. St. yrs. 32 mos. .... ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White~~Single~~ Married  
~~Widowed~~  
or Divorced  
(Write the word.)

6-DATE OF BIRTH.

July 16 1857  
(Month) (Day) (Year)

7-AGE.

64

yrs. .... mos. .... ds.

If LESS than 1 day,

hrs. or .... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer).

Grocery 034

9-BIRTHPLACE.

(State or Country).

Italy

10-NAME OF FATHER.

C Carmatella

11-BIRTHPLACE OF FATHER.

(State or Country).

Italy

12-MAIDEN NAME OF MOTHER.

Mary Catalano

13-BIRTHPLACE OF MOTHER.

(State or Country).

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josephine Bartolero(Address) 614 W. Baltimore St.

15-

MAR 15 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

March 12 1922  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.thereon and from the evidence obtained by said inquest, autopsy or inquiry.find that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Valvular disease of the heart(Duration) yrs. over 10 mos.

CONTRIBUTORY (Secondary)

Don't know

(Signed)

W. H. G. M. D.  
(Coroner)3-15 1922 (Address) Mr. S. S. S.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. .... yrs. .... mos. .... ds. In the State. .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

St. Vincent CemeteryMarch 15, 1922

20-UNDERTAKER.

ADDRESS

George J. Ruth 1735 Harford Ave.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62370

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 Vm

ST. 19 WARD)

## 2-FULL NAME

(a) RESIDENCE. NO. 1711 Vm

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John Herbert

6 DATE OF BIRTH (month, day, and year)

July 26, 1862

7 AGE

Years

Months

Days

59

7

16

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Landress, 041

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

See Montgomery Co. Ind

9 BIRTHPLACE (city or town) (State or country)

Kansas Woodward

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Montgomery Co Ind

12 MAIDEN NAME OF MOTHER

Elizabeth Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Montgomery Co Ind

14

Informant (Address)

Louisa Herbert, 1711 Vm St.

15

MAR 15 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 12, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1922, to March 12, 1922 that I last saw her alive on March 11, 1922, at 2:30 P. m.

and that death occurred, on the date stated above, at The CAUSE OF DEATH\* was as follows:

Uterine Carcinoma

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) William H. Wright, M. D.

(Address) 1309 Preston Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

David Carlin

P. m.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62371

## CERTIFICATE OF DEATH.

D 62371

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 228 Rock St.; 18 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 228 Rock St.; 6 yrs., 0 mos., 0 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

Cauc5-SINGLE,  
MARRIED, S  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

1 (Month) 1 (Day) 1912 (Year)

7-AGE,

6 yrs., 0 mos., 0 ds.If less than 1 day,  
hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,  
(State or Country),Ind

10-NAME OF FATHER,

John Turner11-BIRTHPLACE OF FATHER  
(State or Country),Ind

12-MAIDEN NAME OF MOTHER

Bessie Wise13-BIRTHPLACE OF MOTHER  
(State or Country),Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie Turner(Address) 228 Rock St.

15

MAR 15 1922 ROBERT R. KRAUTER,

Filed....., 191.....  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Mar 13, 1912  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Mar 8, 1912, to Mar 13, 1912,that I saw her alive on Mar 13, 1912,and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH\* was as follows:

Cardiac Dilatation

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY  
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

Mar 14, 1912 (Address) 739 N. Gay St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mount Auburn

DATE OF BURIAL,

Mar 16, 1912

20-UNDERTAKER

Daniel Taylor

ADDRESS

916

City could get no history of any other condition. Probably had chronic valvular lesion.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

*lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

<i>Abortion,</i>	<i>Cellulitis,</i>	<i>Childbirth,</i>	<i>Convulsions,</i>
<i>Hæmorrhage,</i>	<i>Gastritis,</i>	<i>Erysipelas,</i>	<i>Meningitis,</i>
<i>Gangrene,</i>	<i>Miscarriage,</i>	<i>Necrosis,</i>	<i>Peritonitis,</i>
<i>Phlebitis,</i>	<i>Pyæmia,</i>	<i>Septicæmia,</i>	<i>Tetanus.</i>

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (if induced), whether death is directly or indirectly due to the same.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62372

D 62372

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

3 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 29 1846

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

75

9.

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Orange, New Jersey

10 NAME OF FATHER

Benjamin Woodruff

11 BIRTHPLACE OF FATHER (city or town) (State or country)

U.S.

12 MAIDEN NAME OF MOTHER

Jemina Freeman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

U.S.

14

Informant (Address)

Mrs. H. L. Williams, 35 East 25<sup>th</sup> St.

15

MAR 15 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 14 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1921, March 13, 1922.

that I last saw him alive on March 13, 1922.

and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH\* was as follows:

Acute Enteritis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. H. Mayo

M. D.

3/15, 1922 Address)

1 Baltimore, Md

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Rosedale Cemetery n.g. Orange

Mar. 17, 1922

20 UNDERTAKER

ADDRESS

Henry W. Means &amp; Son

205 N. Calvert St.

D 62373

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST.: *1* WARD)2-FULL NAME *Joseph Duffy*(a) RESIDENCE. No. *208 S. Madeira* ST.: WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *3* yrs. *5* mos. *1* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*white*

5 Single, Married, Widowed, or Divorced (write the word)

*single*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Oct. 12<sup>th</sup> 18*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*3**5**1*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Balto. Md.*10 NAME OF FATHER *Andrew J. Duffy*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Balto. Md.*12 MAIDEN NAME OF MOTHER *Elouara Lynch*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Balto. Md.*

14

Informant

(Address)

*Andrew J. Duffy  
208 S. Madeira St.*

15

Filed

*MAR 15 1922*

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 13 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb. 6, 1922, to March 13, 1922.*that I last saw him alive on *March 13, 1922.*and that death occurred, on the date stated above, at *12:45 p. m.*

The CAUSE OF DEATH\* was as follows:

*Myocardial insufficiency*CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

*Lobar pneumonia*

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

*At home*

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

*P. S. & S.*

(Signed)

*Herman Dorf* M. D.

19 (Address)

*St. Joseph's Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Redeemer Cem. Md. 10<sup>th</sup> 1922*

20 UNDERTAKER

ADDRESS

*Lilly & Zeller 405 & 406*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62374

## CERTIFICATE OF DEATH.

B1 D 62374

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital WARD) 2

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Heffner(a) RESIDENCE. No. 622 S. Register st.

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Not stated

6 DATE OF BIRTH (month, day, and year) 1862 1874

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Truck driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore  
Maryland10 NAME OF FATHER John Heffner11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Unknown

12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Unknown

14

Informant  
(Address)Hospital Records  
M.T.H.

15

MAR 15 1922

ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12, 1922

17

I HEREBY CERTIFY, That I attended deceased from

August 19, 1921, to March 12, 1922.that I last saw him alive on March 12, 1922.and that death occurred, on the date stated above, at 11.45 p. m.

The CAUSE OF DEATH\* was as follows:

pulmonary tuberculosis

(duration) yrs. 11 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed)

Francis L. Dado3-13-22 Address Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Trinity CemeteryMarch 15 1922

20 UNDERTAKER

ADDRESS

Lilly & Ziller403 S. W. 45

THIS IS VERY IMPORTANT. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

Changes in age of birth-  
rate were made by  
me on this date 3/20/22  
H. P. Adair

STATE OF MARYLAND,

CITY OF BALTIMORE, to wit:

I Hereby Certify that on this 17th day of March, 1922, before me, the subscriber, a Notary Public of the State of Maryland, in the for the City aforesaid, personally appeared John H. Mintiens and made oath in due form of law that he was acquainted with Henry Heffner, now deceased, he having died on 12th day of March, 1922; that he had known him for about twenty-nine years; that he, the said John H. Mintiens is now forty-six years of age and to the best of his knowledge the said Henry Heffner was a trifle more than a year older than himself, making the said Henry Heffner not more than forty-eight years of age.

*John H. Mintiens*  
.....  
Affiant.

Subscribed and sworn to the day and year  
first above mentioned.

*Elmer J. Hammer*  
.....  
Notary Public.

Witness my hand and Notarial seal.

March 17th, 1922.

Dr. Francis L. Badagliacca,  
Municipal Tuberculosis Hospital,  
Bay View, Md.

Dear Doctor: -

You are respectfully requested to call at this department, to see Dr. G. Hampson Jones, Commissioner of Health, concerning the changing of given age on the transcript issued by this department on the death of Henry Hoffman.

You will please call Monday morning, between the hours of 9:30 and 12:30.

Very respectfully,

Assistant Commissioner of Health.

JPH/vw.



## HEALTH DEPARTMENT—CITY OF BALTIMORE 62375

D 62375

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *15* ST. *15* WARD)

## 2-FULL NAME

(a) RESIDENCE. No. *2612 Walnut St.*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

MAR 15 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

*March 11 22* to *March 14 22*that I last saw him alive on *March 14 22*and that death occurred, on the date stated above, at *11:20 a. m.*

The CAUSE OF DEATH\* was as follows:

*Congenital heart  
disease*CONTRIBUTORY  
(Secondary)18 Where was disease contracted  
if not at place of death?Did an operation precede death? Date *3/11/22*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *John J. Graw*, M. D., 19 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Wheeler Rosedale*

DATE OF BURIAL

*3/15 1922*

20 UNDERTAKER

*John Lewis 1439 E. Calhoun*

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62376

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

107-003 D 62376

Registered No. C.....

City of BALTIMORE: (No. *Mersey Hospital* St. *5* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

*Getel Baer (Baer)*  
*231 N. High St.*

(Residence in Baltimore: No. .... St.; yrs. .... mos. .... ds.)

35 St.; yrs. .... mos. .... ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE

*White*

5-Single, Married, Widowed, or Divorced, (Write the word.) *Married*

6-DATE OF BIRTH

*1862*

(Month) (Day) (Year)

7-AGE

*60*

If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

*Grocery Store*

9-BIRTHPLACE

(State or Country)

*Russia*

10-NAME OF FATHER

*Solomon Baer*

11-BIRTHPLACE OF FATHER

(State or Country)

*Russia*

12-MAIDEN NAME OF MOTHER

*Fagie*

13-BIRTHPLACE OF MOTHER

(State or Country)

*Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Jack Lewis*

(Address)

*1439 E. Baltimore*

15-

Filed

*MAR 15 1922*

ROBERT R. KRAUTER,

Burial Permit Clerk

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

*March 3*

1922

(Month) (Day) (Year)

17-

I HEREBY CERTIFY that I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Valium poisoning*  
*Don't know whether*  
*Victim or not*

CONTRIBUTORY (Secondary)

(Duration) yrs. .... mos. .... ds.

(Signed) *W. H. H. H.* M. D.

(Address) *1439 E. Baltimore*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Hebrew Herring Run*

*3/15 1922*

20-UNDERTAKER

ADDRESS

*Jack Lewis 1439 E. Baltimore*

D 62377 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62377

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1004 E. Lombard St. ST., 3 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

(a) RESIDENCE NO. 1004 E Lombard St. ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown7 AGE Years 57 Months — Days — If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14

Informant (Address) Jack Leurs 1439 E. Lombard St.

15

MAR 15 1922 ROBERT H. KNAUTH, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/14 192217 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1922, to March 13, 1922, that I last saw him alive on March 13, 1922, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH\* was as follows:

Angina Pectoris  
Heart failure(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) Heart failure yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Nathan Helfsoff, M. D., 19 (Address) 117 S. B. Roadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Hebrew Rose Dale

DATE OF BURIAL

3/15 1922

20 UNDERTAKER

ADDRESS

Jack Leurs 1439 E. Lombard St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62378

## CERTIFICATE OF DEATH.

31 D 62378

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

227 Rock

ST.

18

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Abraham Johns

(Residence in Baltimore: No.

227 Rock

St.; 57 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE,

C

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

Mar

## 6-DATE OF BIRTH,

Unk

1865

(Month)

(Day)

(Year)

## 7-AGE,

57

yrs. mos. ds.

## If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular

(b) General nature of industry, business, or establishment in which employed (or employer)

Labor

040

## 9-BIRTHPLACE,

(State or Country),

Maryland

## PARENTS.

## 10-NAME OF FATHER,

Unk

## 11-BIRTHPLACE OF FATHER

(State or Country),

Unk

## 12-MAIDEN NAME OF MOTHER

Unk

## 13-BIRTHPLACE OF MOTHER

(State or Country),

Unk

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

B. H. Johns

(Address)

227 Rock St

## 15-

MAR 15 1922

191

ROBERT R. KRAUTER,

Burial Permit Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Mar 13, 1912

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

July 1911, to Mar 13 1912

that I saw him alive on Mar 12 1912

and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

## (Signed)

Mar 13 1912 (Address) 1370 Taylor

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Mt. Auburn

## DATE OF BURIAL,

Mar 15 1912

## 20-UNDERTAKER

John H. Traden

## ADDRESS

142 W. Hill St



D 62379

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 Bethel Ct. 3 ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolph Mayers

(a) RESIDENCE. No. 1616 Bethel Court ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 29-1920

7 AGE Years 1 Months 6 Days 15 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER John Mayers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Agnes Palamit

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John Mayers (Address) 1616 Bethel Court

15 Filed MAR 15 1922 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 12, 1922, to Mar 14, 1922,

that I last saw him alive on Mar 14, 1922,

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

14 1922 (Address) #2 n Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Trinity

3/16 1922

UNDERTAKER

ADDRESS

Wm. F. Adams 1616 Bethel Court

D 62380 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62380

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 821 Curtis Ave. Curtis Bay St. 25 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Mary Wrobel.

(Residence in Baltimore: No. 821 Curtis Ave. Curtis Bay St.; yrs. 2 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.			CORONER'S CERTIFICATE OF DEATH.	
3-SEX, Female.	4-COLOR OR RACE, White.	5-Single, Married, Widowed, or Divorced, (Write the word.) Single.	16-DATE OF DEATH, March 14th, 1922. (Month) (Day) (Year)	
6-DATE OF BIRTH, January 3rd, 1922. (Month) (Day) (Year)			17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to her death topsy or inquiry.) on the day stated above.	
7-AGE, 2 yrs. 11 mos. 11 ds. If LESS than 1 day, hrs. or min.?			The CAUSE OF DEATH* was as follows: Mitral Insufficiency. Congenital.	
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).			CONTRIBUTORY (Secondary) (Signed) <i>Wm. H. Remond</i> M. D. (Coroner.) March 15, 1922. (Address) 1017 E. Charles St.	
9-BIRTHPLACE, (State or Country), Baltimore, Md.			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
PARENTS:	10-NAME OF FATHER, John Wrobel.	11-BIRTHPLACE OF FATHER, (State or Country), Poland.	18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.	
	12-MAIDEN NAME OF MOTHER, Waleria Kowalczyk.	13-BIRTHPLACE OF MOTHER, (State or Country), Poland.	Where was disease contracted, if not at place of death?.....	
	14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) John Wrobel. (father) (Address) 821 Curtis Ave. Curtis Bay.		Former or usual residence.....	
	15-MAR 5 1922 Filed 1922 <i>SE Wrobel</i> Registrar.		19-PLACE OF BURIAL OR REMOVAL, Holy Cross DATE OF BURIAL, Mar 15, 1922 ADDRESS Wm. H. Remond 516 E. Eastern Ave.	

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62381

62381

## CERTIFICATE OF DEATH.

101-001

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1247 Battery Ave. ST. 24

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Gertrude Naomi Marie Bryant

## (a) RESIDENCE. NO. 1247 Battery Ave. ST. 24

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 2 mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10.30.1920

7 AGE 1 Years 4 Months 14 Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

## 10 NAME OF FATHER

Wallace Bryant

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Northumberland Va

## 12 MAIDEN NAME OF MOTHER

Annie Eble

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

## 14

Informant (Address)

Mr Annie Bryant 1247 Battery Ave

## 15

Filed

MAY 15 1922

J. E. Kilm

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3.14 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

3.4 1922, to 3.14 1922,

that I last saw him alive on 3.14 1922,

and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. 7 ds.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. E. Durlington, M. D.

3.14 1922 (Address) 1026 York Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

Baltimore

3/16 1922

J. F. Sahay

1318 E. 1st St.

D 62382 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001 D 62382

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3206 Foster Ave ST., 26 WARD)

## 2-FULL NAME.

Joseph A. Stahlin

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 3206 Foster Ave ST., 26 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilhelmina Stahlin

6 DATE OF BIRTH (month, day, and year) April 7, 1854

7 AGE Years 67 Months 11 Days 6 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) Switzerland (State or country)

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) Not known (State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country)

14 Informant Benjamin Stahlin

15 MARCH 15 1922 ROBERT A. KRAUTER

Filed

19

Burial Permit Clerk Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1922

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1922, to March 13, 1922, that I last saw him alive on March 13, 1922, and that death occurred, on the date stated above, at 5:50 P. M.

The CAUSE OF DEATH\* was as follows:

Solar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY Myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. J. McAvoy M. D.

3/14, 1922 (Address) 139 S. Ellwood Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Oak Lawn Cem.

20 UNDERTAKER

H. Sander Sons

DATE OF BURIAL

March 16, 1922

ADDRESS

1700 West St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62383

## CERTIFICATE OF DEATH.

113 D 62383

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Windsor Court Apts 45* ST. *5* WARD)2-FULL NAME *George A. Collic*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. *Windsor Ct. Apts* ST. *5* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds.

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*Colored*

5 Single, Married, Widowed,

*Single*

or Divorced (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Nov 23/1921*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs.

or min.

*3**11*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto Md*10 NAME OF FATHER *Harry Collic*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md*12 MAIDEN NAME OF MOTHER *Thomas Green*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md*

14

Informant (Address) *Harry Collic 1313 Argyle Ave*

15

MAR 15 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 13 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*March 1 1922 to March 12 1922*that I last saw him alive on *March 12 1922*and that death occurred, on the date stated above, at *5 A* m.

The CAUSE OF DEATH\* was as follows:

*Broncho Pneumonia*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death?

*Home*

Did an operation precede death?

*no*

Date of

Was there an autopsy?

*no*

What test confirmed diagnosis?

*Clinical*

(Signature)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*St. Ambrose 1413 St. Hall**3/15/22*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62384

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2006 Druid Hill Ave.)

WARD

## 2-FULL NAME

Clara Webster Johnson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2006 Druid Hill Ave.)

St.; 15 yrs., 1 mos., 1 da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)  
Widow

## 6-DATE OF BIRTH,

Dec 26th 1879  
(Month) (Day) (Year)

## 7-AGE,

42 yrs., 2 mos., 15 da.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work... Home -  
(b) General nature of industry, business, or establishment in which employed (or employer)... Housewife

## 9-BIRTHPLACE, (State or Country),

Warrenton Va

## 10-NAME OF FATHER,

Elzey Robinson

## 11-BIRTHPLACE OF FATHER (State or Country),

Va

## 12-MAIDEN NAME OF MOTHER

Hester Jenkins

## 13-BIRTHPLACE OF MOTHER (State or Country),

Va

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarissa Jenkins

(Address) 2006 Druid Hill Ave

## 15-

22615 1871  
Filed 1922

ROBERT R. KRAUTER,

Burial Permit Officer

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Mar 12th 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Mar 11th 1922, to Mar 12th 1922,

that I saw her alive on Mar 12th 1922,

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(Duration) ... yrs. ... mos. ... da.

## CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... da.

(Signed) Harry G. Brown M. D.

Mar 12th 1922 (Address) 1501 President St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. ... mos. ... da. in the State yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Mt Auburn Cemetery March 15th 1922

## 20-UNDERTAKER

John H. Toddum John H. Toddum

D 62385 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1424 Mc Elderry St. 5 WARD)

2-FULL NAME

(Residence in Baltimore: No. 4424 Mc Elderry St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH

(Month)

(Day)

(Year)

7-AGE

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.  
(State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

ROBERT R. KRAUTER

Registrar

MAR 15 1922

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

3-14-1922 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Mrs Robert J. Elliot

D 62386

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 D 62386

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO) Municipal Tuberculosis Hospital (St. 7) WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Burrell Hall

(a) RESIDENCE. No. 906 Rutland ave.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

ds. How long in U. S., If of foreign birth? N.C. yrs. 5 mos. in Balt.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day. hrs. or min.
22				

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer 863

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)  
(State or country) North Carolina

10 NAME OF FATHER Henry Hall

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mary Sasser

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) North Carolina14 Informant Hospital Records  
(Address) M.T.H.15 MAR 15 1922 ROBERT R. KRAUTER,  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1922

17 I HEREBY CERTIFY, That I attended deceased from  
December 13, 1921, to March 14, 1922.  
that I last saw him alive on March 13, 1922.

and that death occurred, on the date stated above, at 12:02 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Badolli

8-14-22 Address Municipal Tbc. Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Int- Aurlon Cen

March 17 1922

20 UNDERTAKER

ADDRESS 1725-

Mrs Robert A Elliott

Ashland



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62387

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

WARD)

## 2-FULL NAME

(a) RESIDENCE, No.

(Usual place of abode)

Length of residence in city or town where death occurred

40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

WARD.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Husband

6 DATE OF BIRTH (month, day, and year)

7 AGE

60

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Maryland

10 NAME OF FATHER

John S. Parker

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Ellen High

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant  
(Address)Mary Parker  
18 E 20th St

15

Filed

MAR 13 1922

ROBERT R. KRAUTER  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar., 13 1922

17

I HEREBY CERTIFY, That I attended deceased from

Mar., 2, 1922, to Mar., 13, 1922

that I last saw him alive on Mar., 13, 1922

and that death occurred, on the date stated above, at 2:10 P. M.

The CAUSE OF DEATH\* was as follows:

Bronchial Asthma

(duration) 2 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. A. Johnson.

, 19 (Address) 211 - 8 - 23 W. St. Balt.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn Cem

March 16 1922

20 UNDERTAKER

ADDRESS

Mrs Robert A. Elliott

1725 Ashland St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62388

## CERTIFICATE OF DEATH.

31 D 62388

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

807 Kenwood Ave

ST.,

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Joseph A. Missbach

## (a) RESIDENCE NO.

807 N. Kenwood Ave

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

✓

## 6 DATE OF BIRTH (month, day, and year)

Jan 15, 1886

## 7 AGE

Years

Months

Days

36

1

24

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Superintendent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md

## 10 NAME OF FATHER

Nicholas J. Missbach

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

## 12 MAIDEN NAME OF MOTHER

Isabelle Swick

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md

## 14

Informant

(Address)

Charles H. Missbach

807 N. Kenwood Ave

## 15

File

MAR 15 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 14, 1922

## 17

I HEREBY CERTIFY, That I attended deceased from Jan 27, 1922, to March 14, 1922, that I last saw him alive on March 14, 1922,

and that death occurred, on the date stated above, at 10-0 m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Exhaustion

(duration) 2 yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. K. Smith, M. D.

701 N. Kenwood Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Holy Redeemer Cemetery

Mar 17, 1922

## 20 UNDERTAKER

## ADDRESS

Geo. M. Fink &amp; Son

811 N. Wolfe St

D 62389

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62389

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 North Monroe St. ST.; 20 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

William Henry Stember

## (a) RESIDENCE. NO.

5 North MonroeST., 20 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 11 mos. 23 ds. How long in U. S., if of foreign birth? Same mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofSarah A. Stember

## 6 DATE OF BIRTH (month, day, and year)

April 6, 1853

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.681114

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Drug Store

(b) General nature of industry, business, or establishment in which employed (or employer)

02

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore  
Maryland

## 10 NAME OF FATHER

George Stember

## PARENTS

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Balto  
Maryland

## 12 MAIDEN NAME OF MOTHER

unknown13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Balto  
md.

## 14

Informant  
(Address)Mrs. Sarah H. Stember  
5 N. Monroe St.

## 15

Filed

MAR 15 1922

ROBERT H. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1922

17

I HEREBY CERTIFY, That I attended deceased from

February 27, 1922, to March 13, 1922.that I last saw him alive on March 13, 1922.and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH\* was as follows:

Cerebral Thrombosis

(duration)

10 mos. 10 ds.CONTRIBUTORY  
(Secondary)Arterial Sclerosis

(duration)

3 yrs. 10 mos. 10 ds.18 Where was disease contracted  
if not at place of death?at homeDid an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt. G. L. Lumsden, M. D.March 19 1922 (Address) 11 E. Fayette St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Int. Oliver CemeteryMarch 16 1922

## 20 UNDERTAKER

George J. Smith

## ADDRESS

Fayette St.

D 62390

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Russell & Putnam* ST.; *25* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *Russell & Putnam* St.; ..... yrs., ..... mos. .... ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE,

*Col*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Infant*

## 6-DATE OF BIRTH,

*Oct 2, 1921*  
(Month) (Day) (Year)

## 7-AGE,

*5* yrs., *11* mos., ..... ds.

If LESS than 1 day, ..... hrs. or ..... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Infant*

## 9-BIRTHPLACE, (State or Country),

*Md.*

## 10-NAME OF FATHER,

*Charles T. Parker Jr.*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Md.*

## 12-MAIDEN NAME OF MOTHER

*Gertrude Brooks*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Md.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

*Charles Parker, Putnam*

## 15-

MAR 15 1922

ROBERT R. KRAUTER,  
Burial Permit Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*March 13, 1922*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*March 12 1922 to March 13 1922*that I saw ~~him~~ alive on *March 13* 1922,and that death occurred, on the date stated above, at *9 p.m.*

The CAUSE OF DEATH\* was as follows:

*Broncho pneumonia*(Duration) *no* yrs. *no* mos. *6* ds.

## CONTRIBUTORY (Secondary)

*Intussusception*  
(Duration) *no* yrs. *no* mos. *5* ds.

(Signed)

*Raymond E. Allen* M. D.*March 14, 1922* (Address) *Latrobe*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Mt Auburn*

## DATE OF BURIAL,

*3/15, 1922*

## 20-UNDERTAKER

*Samuel S. Sweeney*

## ADDRESS

*58 Middle*



D 62391

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62391

## 1. PLACE OF DEATH.

CITY OF BALTIMORE: (No. 705 Baker ST., 15 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Emily Johnson

## (a) RESIDENCE NO.

705 BakerST., 15 WARD

(Usual place of abode)

(If non-resident give city and town and State)

Length of residence in city or town where death occurred 20 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widow

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofEzekiel Johnson

## 6 DATE OF BIRTH (month, day, and year)

Not known 1871

## 7 AGE

51

Years

Months

Days

If LESS than  
1 day, 0 hrs.  
or 0 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

070

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Va.

## 10 NAME OF FATHER

Jefferson Johnson

## 11 BIRTHPLACE OF FATHER (city or town)

Va.

(State or country)

## 12 MAIDEN NAME OF MOTHER

Georgia Jones

## 13 BIRTHPLACE OF MOTHER (city or town)

Va.

(State or country)

## 14

Informant  
(Address)Estelle Shrother705 Baker St.

## 15

MAR 15 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 15, 1922, to Mar 11, 1922.that I last saw him alive on Mar 10, 1922.and that death occurred, on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH\* was as follows:

Cancer of Uterus(duration) 7 yrs. 0 mos. 0 ds.CONTRIBUTORY  
(Secondary)(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical Findings(Signed) William F. Hays M. D.Mar 11, 1922 (Address) 1928 Penna Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

St. Ambrose Ave  
Samuel Hensley3/15 1922  
57810  
Biddle

## HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 62392

D 62392

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1732 Bolton St. ST.; 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Mary Whitehurst

(Residence in Baltimore: No. 1732 Bolton St. St.; 54 yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,  
MARRIED, Married  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

March 16th, 1867  
(Month) (Day) (Year)

7-AGE,

54 yrs. 11 mos. 25 ds.

If LESS than 1 day,  
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular  
kind of work.

None

(b) General nature of industry, business, or establishment in which  
employed (or employer).

9-BIRTHPLACE,

(State or Country),

Elizabethtown, Pa.

10-NAME OF  
FATHER,

Abraham R. Redsecker

11-BIRTHPLACE  
OF FATHER  
(State or Country),

Elizabethtown, Pa.

12-MAIDEN NAME  
OF MOTHER

Mattie Jean Pfeffer

13-BIRTHPLACE  
OF MOTHER  
(State or Country),

Carlisle, Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William H. Whitehurst

(Address) 1732 Bolton St.

MAR 15 1922

Filed..... 191.....

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 13, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from  
Jan 11 1922, to March 13 1922,  
that I saw him alive on March 13 1922,  
and that death occurred, on the date stated above, at 6:20 P.M.

The CAUSE OF DEATH\* was as follows:

Apoplexy  
Left Hemiplegia  
(Duration)..... yrs. .... mos. .... ds.CONTRIBUTORY  
(Secondary)(Signed) John R. Heiermeyer, M.D.  
March 13 1922 (Address) 3524 York Road.\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,  
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Louson Park Cem.

Mar 15, 1922

20-UNDERTAKER

ADDRESS

Joseph B. Cook

1003 N. Baltimore St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62393

D 62393

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1845 M. Henry ST.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Johnson(Residence in Baltimore: No. 1845 M. Henry St.; .....yrs., .....mos., .....ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single6-DATE OF BIRTH, Nov. 19, 1880

(Month) (Day) (Year)

7-AGE, 40 yrs., 3 mos., 21 ds.

If LESS than 1 day, .....hrs. or .....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....Huckster  
(b) General nature of industry, business, or establishment in which employed (or employer).....0459-BIRTHPLACE, (State or Country), Balto.10-NAME OF FATHER, Chas. Johnson11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.12-MAIDEN NAME OF MOTHER Caroline Cambridge13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. W. Clark(Address) 1845 M. Henry St.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 19, 1922

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 28, 1922, to March 12, 1922, that I saw him alive on March 11, 1922, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH\* was as follows:

Herpes Zoster

(Duration) .....yrs., .....mos., .....ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) .....yrs., .....mos., .....ds.

(Signed) M. E. Smith M. D......, 1922 (Address) 1845 Calhoun

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs., .....mos., .....ds. In the State .....yrs., .....mos., .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western CemeteryDATE OF BURIAL, Mar. 15, 192220-UNDERTAKER, Geo. L. SchmittADDRESS 101 E. Pratt St.15-  
MAR 15 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62394

## CERTIFICATE OF DEATH

62394

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 25 Mary Ave ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. 25 Mary Ave ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 5 1847

7 AGE 74 Years 10 Months 29 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

10 NAME OF FATHER John Krugg.

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Not known.

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mrs. Mary M. Krugg. (Address) 25 Mary Ave

15 Filled by ROBERT R. KRAUTER, Registrar Burial Permit Clerk. MAR 15 1922

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1922

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1922, to March 12, 1922

that I last saw him alive on March 10, 1922

and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH\* was as follows:

Acute Bulbar Paralysis (hemorrhage)

(duration) yrs. mos. 9 ds.

CONTRIBUTORY Chronic Myocarditis (Secondary)

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Morris B. Green, M. D.

3/14, 1922 (Address) Hamilton, Baltimore Md

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Carmel Cem. Mar 16 1922

20 UNDERTAKER ADDRESS

J. Freeman 220 Bond St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62395

D 62395

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2638 *Hampton Ave* 17 WARD)

## 2. FULL NAME

*Paul Sheridan Foster*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 2638 *Hampton Ave* ST.

(Usual place of abode)

## WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Nov 19-1920*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant (Address)

## 15

MAR 15 1922

ROBERT K. KRAUTER,

Bureau Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 15 1922*

## 17

I HEREBY CERTIFY that I attended deceased from

*Mar 13 1922* to *Mar 15 1922*that I last saw him alive on *Mar 15 1922*and that death occurred, on the date stated above, at *5 a. m.*

The CAUSE OF DEATH\* was as follows:

*Cardiac Failure*

## CONTRIBUTORY (Secondary)

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

*None*  
*112 W. 30th St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

*Baltimore*

## 20 UNDERTAKER

*J. M. Cook*

## DATE OF BURIAL

*3/16/22*

## ADDRESS

*502 E. North*

D 62396

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62396

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1213 S. Clinton

ST.: No WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Audrey Gunther

## (a) RESIDENCE. NO.

1213 S. Clinton

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred - yrs. - mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Feb. 28, 1922

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

14

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

## 10 NAME OF FATHER

David Gunther

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

South Carolina

## 12 MAIDEN NAME OF MOTHER

Gladys M. Smith

## 13 BIRTHPLACE OF MOTHER (city or town)

Baltimore, Md.

## 14 Informant

Gladys M. Gunther

(Address)

1213 S. Clinton St.

## 15

5 1922

Robert P. Harrison,

Registrar

Burial Permit Clerk:

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 28th 1922 to March 14th 1922 that I last saw her alive on March 14th 1922 and that death occurred, on the date stated above, at 11:45 P. M.

The CAUSE OF DEATH\* was as follows:

Premature Birth (about 7 1/2 mo)

(duration) yrs. mos. 15 ds.

## CONTRIBUTORY (Secondary)

Inanition

(duration) yrs. mos. 10 ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) St. H. Schwartz, M. D.

3/15/1922 (Address) 737 S. E. Eager Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Schwartz's Cemetery

March 16 1922

## 20 UNDERTAKER

Zinkler + Zinkler Bros

## ADDRESS

1739 E. Eager St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62397

## CERTIFICATE OF DEATH

118-001  
D 62397

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Square* ST.: *Hospital* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Catherine T. Hutchins*(a) RESIDENCE NO. *343* *Swygum Ave.* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *66* yrs. *9* mos. *12* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Female White Married*

5a If married, widowed or divorced

(or) WIFE of

*J. Frank Hutchins*6 DATE OF BIRTH (month, day, and year) *June 3 1855*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*66 9 12*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

*037*

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md* (State or country)10 NAME OF FATHER *Mrs. C. Frederick*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Frederick Co Md*12 MAIDEN NAME OF MOTHER *Elizabeth Coombe*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Montgomery Co Md*

14

Informant (Address)

*J. F. Hutchins 343 Swygum Ave*

15

Filed

*Robert P. Harrison,*

Registrar

5 1922

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 15 1922*

17

I HEREBY CERTIFY That I attended deceased from *New 12* 1922, to *New 10* 1922.that I last saw him alive on *March 14* 1922.and that death occurred, on the date stated above, at *4 1/2 PM*.

The CAUSE OF DEATH\* was as follows:

*Strangulated Hernia*  
*Hernia*(duration) yrs. mos. ds. *3*

CONTRIBUTORY

(Secondary)

*Strangulated Hernia*(duration) yrs. mos. ds. *20*

18 Where was disease contracted

If not at place of death?

*at home*

Did an operation precede death?

*Yes* Date of *March 13 1922*

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Operation*

(Signed)

*J. B. Walbrohouse* M. D.Address *1901 Eutan Pl., City*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Cathedral**March 18 1922*

20 UNDERTAKER

ADDRESS

*Geo W Little**2700 Edmondson*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62398

## CERTIFICATE OF DEATH.

D 62398

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *242 Laurens*ST., *14* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Louisa A. Doyle*

## (a) RESIDENCE NO.

*242 Laurens*

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*single*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Mar 6 1852*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*70**-**9*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*La.*

## 10 NAME OF FATHER

*Walter J. Doyle*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ireland*

## 12 MAIDEN NAME OF MOTHER

*Celestia Riordan*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*La.*

## 14

Informant (Address)

*Isabel Evans Sands 242 Laurens St*

## 15

Robert P. Harrison,

Filed 5 1922

19

Registrar

Burial Permit

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 15 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*Oct 14 1895 to March 15 1922*that I last saw her alive on *March 15 1922*and that death occurred, on the date stated above, at *12:45 a m.*

The CAUSE OF DEATH\* was as follows:

*Diabetes*(duration) *26* yrs. — mos. — ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death? *Home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Examination of urine*(Signed) *John J. King* M. D.1922 (Address) *1425 Eulaw Place*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

*New Cathedral Mar 17 1922*

## 20 UNDERTAKER

## ADDRESS

*John O. Mitchell 1201 W. Fayette St*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62399

D 62399

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 961 N. Chester

ST.: 7

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. 961 N. Chester

ST.: 7

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 38 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Blaze Kadler

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Homemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Bohemia

10 NAME OF FATHER

Kadler Pyra

PARENTS

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Bohemia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Bohemia

14

Informant (Address)

Blaze Kadler 961 N. Chester

15

5 1922

Robert P. Harrison, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 13 1922

17

I HEREBY CERTIFY, That I attended deceased from

Mar 10 1922 to Mar 15 1922

that I last saw him alive on Mar 13, 1922

and that death occurred on the date stated above, at \_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Griff

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Unknown

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

Pneumonia

(Signed) 3-16-22 F. J. Harrison, M. D.

19 (Address)

100 N. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oak Hill

Mar 16 1922

20 UNDERTAKER

ADDRESS

Frank Crackelton

19066 Ashland

D 62400

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

11-001  
D 62400  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 Hannevan C. ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME Mary Henne

(Residence in Baltimore: No. 1817 Hannevan C.

St.; 28 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE,

White

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

## 6-DATE OF BIRTH,

Unknown, 1.....  
(Month) (Day) (Year)

## 7-AGE,

65

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

## 9-BIRTHPLACE,

(State or Country),

Bohemia

## 10-NAME OF FATHER,

Amelie Hannevan

## 11-BIRTHPLACE OF FATHER (State or Country),

Bohemia

## 12-MAIDEN NAME OF MOTHER

Henne

## 13-BIRTHPLACE OF MOTHER (State or Country),

Bohemia

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Henne

(Address) 1817 Hannevan C.

## 15-

Filed..... 191.....

5 1922

Robert F. Harrison Registrar.

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

May 13, 1912  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Mar 11 1912, to Mar 13 1912

that I saw him alive on Mar 13 1912

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH\* was as follows:

grippe

(Duration)..... yrs. mos. ds. 3

## CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds. 2

(Signed) F. F. Harrison M. D.

3-15-12, 1912 (Address) 810 North Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer

## DATE OF BURIAL,

Mar. 16, 1912

## 20-UNDERTAKER

Frank Grackson

## ADDRESS

1916 North Ave.

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 62401

D 62401

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1425 Orleans ST.; 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. 1425 Orleans ST.; WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE COT. 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of

(Name)

6 DATE OF BIRTH (month, day, and year)

7 AGE 47 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 Mar 1922

17

I HEREBY CERTIFY, That I attended deceased from 17 Feb. 1922, to 12 Mar. 1922, that I last saw him alive on 11 Mar. 1922, and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH\* was as follows:

Thromboplegia

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Mayfield Boyd, M. D.

14319 (Address) 421 N. Caroline St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

National Cemetery Mar 15 1922

20 UNDERTAKER

ADDRESS

R. B. Gross 1405 McElderry

PARENTS  
Important: See instructions on back of certificates.

Burial Permit Clerk.

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Apoplectic.*  
*Not luetic in origin.*



D 62402

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62402

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 324 S. Collington Ave. ST.: 1 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian E. Klages

(a) RESIDENCE. No. 324 S. Collington Ave. ST.: WARD.

(Usual place of abode)  
Length of residence in city or town where death occurred 36 yrs. 11 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced  
HUSBAND of Harry E. Klages  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 2 1885

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
36 11 11

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.  
(State or country)

10 NAME OF FATHER James F. Seth

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.  
(State or country)

12 MAIDEN NAME OF MOTHER Laura Warner

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.  
(State or country)14 Informant Mrs. Cahell  
(Address) 2400 Erdman Ave.15 5-19-22 Robert P. Harrison, Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1922

17 I HEREBY CERTIFY, That I attended deceased from March 10 1922, to March 13 1922

that I last saw her alive on March 13 1922

and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

CONTRIBUTOR (Secondary) Cardiac Failure (duration) yrs. mos. ds. 3

18 Where was disease contracted At home  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs  
(Signed) C. S. Miller M. D.

2/14/22 (Address) 4085 Pat Okan

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cedar Hill Lane

Mar 16 1922

20 UNDERTAKER

ADDRESS

Jew McCully

130 E. 50th Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62403

## CERTIFICATE OF DEATH.

D 62403

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland General Hospital* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. *172 Laverne Ave.* ST., *Landsdowne, Md.*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *8* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Charles Walz*6 DATE OF BIRTH (month, day, and year) *May 30, 1878*

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*44**9**15*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

*037*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Maryland*

## 10 NAME OF FATHER

*Louis Hardy*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Maryland*

## 12 MAIDEN NAME OF MOTHER

*Ellen Barnett*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Maryland*

## 14

Informant  
(Address)*Charles H. Walz  
Landsdowne*

## 15

Filed

*Robert P. Harrison,*

Registrar

*5 1922*

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 14, 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*March 7, 1922, to March 14, 1922,*that I last saw him alive on *March 14, 1922,*and that death occurred, on the date stated above, at *2:25 p.m.*

The CAUSE OF DEATH\* was as follows:

*Ruptured Appendicitis  
General Peritonitis*(duration) yrs. mos. *9* ds.CONTRIBUTORY  
(Secondary)*Cardiac Failure*(duration) yrs. mos. *2* ds.

18 Where was disease contracted

if not at place of death? *172 Laverne Ave. Landsdowne*Did an operation precede death? *Yes* Date of *March 8, 1922*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *John W. Mott* M. D., 19 (Address) *Md. General Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Walkersville Md**3/16 1922*

## 20 UNDERTAKER

## ADDRESS

*J. Frew McConally 130 E. Fort*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

1535-24  
62404

## CERTIFICATE OF DEATH.

113 D 62404

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 7 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Jerome Haywood

## (a) RESIDENCE. NO.

815 N. Rose

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. life mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

May 13<sup>th</sup> 1921

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

101

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Lab. 800

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

## 10 NAME OF FATHER

Jerome Haywood

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md.

## 12 MAIDEN NAME OF MOTHER

Lydella May Insley

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

## 14

Informant. (Address)

JOHNS HOPKINS HOSPITAL

## 15

Filed

Robert P. Harrison,

Registrar

5 1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 14 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan. 30<sup>th</sup> 1922, to March 14<sup>th</sup> 1922that I last saw him alive on March 14<sup>th</sup> 1922and that death occurred, on the date stated above, at 8:10 P. M.

The CAUSE OF DEATH\* was as follows:

Diarrhoea (not dysentery)(duration) yrs. 3 mos. ds.

## CONTRIBUTORY (Secondary)

Influenza meningitis(duration) yrs. mos. 3 ds.

## 18 Where was disease contracted

if not at place of death?

meningitis in hospitalDid an operation precede death? no - Date ofWas there an autopsy? no

What test confirmed diagnosis?

Smears, punctures & culture

(Signed)

Horace G. Stewart, M. D.

3/15/22

(Address) Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Wingate Wharf Co. Md.3/16 1922

## 20 UNDERTAKER

## ADDRESS

Philip Herwig2016 Orleans

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62405

## CERTIFICATE OF DEATH.

D 62405

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital* ST. *10* WARD)

## 2-FULL NAME

*Kenneth Schaeffer*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE. No.

*615 Aull St*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

*1* yrs. *11* mos. *12* ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*male*

## 4 COLOR OR RACE

*white*

## 5 Single, Married, Widowed, or Divorced (write the word)

*single*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*April 3-1920*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*1**11**12*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Balto.**md.*

## 10 NAME OF FATHER

*Bleo Schaeffer*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Orangeville**md.*

## 12 MAIDEN NAME OF MOTHER

*Gros Haulow*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balto.**md.*

## 14

Informant (Address)

*Walter G. Schaeffer*  
*615 Aull St.*

## 15

Filed

*Robert P. Harrison,*

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 15* 19*22*

## 17

I HEREBY CERTIFY, That I attended deceased from

*March 9*, 19*22*, to *March 15*, 19*22*,that I last saw him alive on *March 14*, 19*22*.and that death occurred, on the date stated above, at *4:55 a* m.

The CAUSE OF DEATH\* was as follows:

*Diphtheria, laryngeal & faucial*(duration) yrs. mos. *8* ds.

## CONTRIBUTORY (Secondary)

*Pneumonia*(duration) yrs. mos. *5* ds.

## 18 Where was disease contracted if not at place of death?

*at home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

*Culture (+)*(Signed) *Bella Gowan*, M. D., 19 (Address) *Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*MT. Carmel**3/16* 19*22*

## 20 UNDERTAKER

*Philip Herwig*

## ADDRESS

*2016*  
*Oleans*



(Weinbauer)

# HEALTH DEPARTMENT—CITY OF BALTIMORE D 62406

D 62406

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST.: *9* WARD)2-FULL NAME *Benedict Weinbauer*(a) RESIDENCE. No. *St. Joseph's Hospital* ST.: WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *66* yrs. — mos. — ds. How long in U. S., if of foreign birth? *66* yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*

5a If married, widowed, or divorced  
HUSBAND of *Indiana*  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Not Known*

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*81* — —

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Germany*  
(State or country)10 NAME OF FATHER *Not Known*11 BIRTHPLACE OF FATHER (city or town) *Not Known*  
(State or country)12 MAIDEN NAME OF MOTHER *Not Known*13 BIRTHPLACE OF MOTHER (city or town) *Not Known*  
(State or country)

14

Informant *Records of St. Joseph's Hosp*  
(Address) *Quakers - Oliver St*5<sup>1922</sup> Robert P. Harrison,

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 15 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan. 26, 1922, to March 15, 1922,*  
that I last saw him *live on March 15, 1922,*

and that death occurred, on the date stated above, at *3:30 a. m.*

The CAUSE OF DEATH\* was as follows:

*Myocardial Insufficiency*

(duration) yrs. *2* mos. ds.

CONTRIBUTORY (Secondary)

*Chronic nephritis*(duration) *10* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *P. S. & S.*(Signed) *Frank C. Marino* M. D.19 (Address) *St. Joseph's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Redeemer Cemetery March 16, 1922*

20 UNDERTAKER

ADDRESS

*Henry Horst Sen 1301 E. Epp*

154450 HEALTH DEPARTMENT—CITY OF BALTIMORE  
D 62407

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL

ST. 7

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Rosemary Sweigman

## (a) RESIDENCE. No.

503 E. St. Washington, D.C.

## WARD.

Wash, D.C.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female White Single

## 4 COLOR OR RACE

## 5 (Single, Married, Widowed, or Divorced (write the word))

## 5a If married, widowed, or divorced

HUSBAND or WIFE Mrs. Sibyl Sweigman Mother

## 6 DATE OF BIRTH (month, day, and year)

Aug. 11, 1914.

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Ill.

## 10 NAME OF FATHER

Eugene Sweigman

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Kans.

## 12 MAIDEN NAME OF MOTHER

Sibyl Betto

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Kans.

## 14

Informant (Address)

JOHNS HOPKINS HOSPITAL

## 15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 14, 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

March 13, 1922, to March 14, 1922,

that I last saw her alive on March 14, 1922,

and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH\* was as follows:

colossal growth of the brain over left side

(duration) 6 yrs. — mos. — ds.

## CONTRIBUTORY (Secondary)

enlarged thyroid gland

(duration) 6 yrs. 2 mos. 3 ds.

## 18 Where was disease contracted

If not at place of death? unknown

## Did an operation precede death?

Yes

Date of March 14, 1922

## Was there an autopsy?

Yes

## What test confirmed diagnosis?

operation

(Signed) P. B. MacReady, M. D.

(Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Baltimore Cemetery March 16, 1922

## 20 UNDERTAKER

## ADDRESS

Joseph A. Avers 221 N. B. Ave.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Angioma which  
had become calcified.  
Classified as tumor  
of brain.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62408

D 62408

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE (No. 1923 Harlem Ave. ST., 16 WARD)

## 2. FULL NAME

Mary E. Rempp.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1923 Harlem Ave

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a ~~Married, widowed, or divorced~~

WIFE of

T Robert Rempp

## 6 DATE OF BIRTH (month, day, and year)

March 4 1857

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

65

0

9

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Maryland

## 10 NAME OF FATHER

George Bitz

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Not known

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

## 14

Informant (Address)

T Robert Rempp 1923 Harlem Ave

## 15

Robert I. Harrison

1922

19

Burial Permit Clerk, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1922

17

I HEREBY CERTIFY, That I attended deceased from

Mar 8 1922 to Mar 13 1922

that I last saw her alive on Mar 13 1922

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Arterio Sclerosis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Paralysis

(Signed)

J. J. Byrd, M. D.

3/14/22 (Address) 1405 Edmondson

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Loudon Park

## DATE OF BURIAL

3-16-22

## 20 UNDERTAKER

Mrs Chas A G Rehr Arlington Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62409

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1036 W. Fayette

ST.: 18 WARD)

2-FULL NAME Doris Viola Wiggington

(a) RESIDENCE. No Child's Nursery—Schneider & Mulberry STS  
(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 18 ds. How long in U. S., if of foreign birth? yrs mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug-24-1920

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
1 6 18

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none off

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Ind.  
(State or country)

10 NAME OF FATHER Luke B. Wiggington

11 BIRTHPLACE OF FATHER (city or town) Balto Ind.  
(State or country)

12 MAIDEN NAME OF MOTHER Audrey May Hush

13 BIRTHPLACE OF MOTHER (city or town) Balto Ind.  
(State or country)14 Informant Audrey A. Wiggington  
(Address) 1036 W. Fayette St.

15 Filed Robert P. Harrison,

Registrar

1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1922

17 I HEREBY CERTIFY, That I attended deceased from March 12 - 1922, to March 14, 1922, that I last saw her alive on March 14 - 1922, and that death occurred, on the date stated above, at 8:30 P. M. The CAUSE OF DEATH\* was as follows:

Influenza.

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Child's Nursery Schneider &amp; Mulberry

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chester Riland, M. D.

3-15, 1922 Address 2532 Edmondson Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park.

DATE OF BURIAL

3-16-1922

20 UNDERTAKER

George J. Smith

ADDRESS /

W Fayette St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62410

D 62410

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ST.,

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female Aged Widower  
If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Unknown 1876

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, .... hrs.  
or .... min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 12 100

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Cassie Seward

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15

Filed

1922

Robert P. Hartley, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1922

17

I HEREBY CERTIFY, That I attended deceased from  
Sept. 21, 1921, to March 13, 1922,  
that I last saw her alive on March 13, 1922  
and that death occurred, on the date stated above, at 3.45 A. M.

The CAUSE OF DEATH\* was as follows:

Apoplexy

Paralysis &amp; Bright Disease

(duration) yrs. mos. 3 da.

CONTRIBUTORY  
(Secondary)

Paralysis &amp; Bright Disease (duration) 1 yrs. 7 mos. 10 da.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. W. Keeney M. D.

(Address) 708 E. 10th St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt. Auburn Cemetery

3/16/22

20 UNDERTAKER

ADDRESS

John B. Pye #102 E. Mulberry St.

D 62411

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *107 S. Register St.*ST. *V* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Josephine Albert.*

(a) RESIDENCE. NO.

*107 S. Register St.*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Mar 10-1922*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*4*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*

10 NAME OF FATHER

*Frank Albert.*

11 BIRTHPLACE OF FATHER (city or town)

*Balto.*

(State or country)

*Md.*

12 MAIDEN NAME OF MOTHER

*Anna Gummert*

13 BIRTHPLACE OF MOTHER (city or town)

*Baltimore*

(State or country)

*Md.*

14

Informant (Address)

*Frank Albert.  
107 S. Register St.*

15

Filed

*Robert P. Harrison*

Registrar

1922

*Burial Permit Clerk.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 14 1922*17 I HEREBY CERTIFY, that I attended deceased from *Mar 10 22* to *Mar 14 22*that I last saw him alive on *Mar 14 22*and that death occurred, on the date stated above, at *5-4* m.

The CAUSE OF DEATH\* was as follows:

*Pruritic Eczema*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

*3/14/22 Dr. J. H. Russell, M.D.  
8912 Kennedy Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Holy Redeemer Ch.*

DATE OF BURIAL

*March 10 1922*

20 UNDERTAKER

*Lilly & Zeiler*

ADDRESS

*403 S. W. 9th*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62412

D 62412

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

WARD)

## 2-FULL NAME

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE. NO.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Julia A. Woodall*

6 DATE OF BIRTH (month, day, and year) *Dec 11, 1859*

7 AGE Years *62* Months *4* Days *3* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant (Address)

## 15

Filed

1927

ROBERT I. CARLSON,

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-14* 19*22*

17 I HEREBY CERTIFY, That I attended deceased from *Aug 25*, 19*20*, to *March 14*, 19*22*, that I last saw him alive on *3-12*, 19*22*, and that death occurred, on the date stated above, at *9* A. M.

The CAUSE OF DEATH\* was as follows:

*Chronic Nephritis*(duration) *2* yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Urinalis*(Signed) *Leonard E. Brach* M. D.. 19 (Address) *2231 St Paul St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*London Park Cem Inds, 1922*

## 20 UNDERTAKER

## ADDRESS

*Eschman & Son* *Harmon*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62413

D 62413

## CERTIFICATE OF DEATH.

31

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *127 McClement* ST.; *23* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. *127 McClement* ST.; *23* WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *62* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*

5a If married, widowed, or divorced

HUSBAND of *Eddie Lewis*  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Dec 28, 1859*7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*62 4 13*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Carpenter*(b) General nature of industry, business, or establishment in which employed (or employer) *Foundry*(c) Name of employer *Stevens R. Carr*9 BIRTHPLACE (city or town) *Baltimore*  
(State or country) *Md.*10 NAME OF FATHER *John Lewis*11 BIRTHPLACE OF FATHER (city or town) *Germany*  
(State or country)12 MAIDEN NAME OF MOTHER *Jeretta Bricker*13 BIRTHPLACE OF MOTHER (city or town) *Va*  
(State or country)14 Informant *Mrs. Clippes*  
(Address) *127 McClement St.*15 Filed *1922* *Robert P. Harrison,* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 13 1922*17 HEREBY CERTIFY, That I attended deceased from *Jan 1, 1922* to *Mar 13, 1922*  
that I last saw him alive on *Mar 12, 1922*  
and that death occurred, on the date stated above, at *6 A* m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis*  
(duration) *Indefinite* yrs. mos. ds.  
*Exhaustion*  
CONTRIBUTORY (Secondary) (duration) yrs. mos. *7* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physically*  
(Signed) *W. Campbell* M. D.  
19 (Address) *1644 Hanover*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Mount Olivet Cem* DATE OF BURIAL *Mar 16 1922*20 UNDERTAKER *E. Schuman Son* ADDRESS *1037*

Burial Permit Clerk

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62414

D 62414

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1314 Hollins

ST. 19

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME Kate Fissel

(Residence in Baltimore: No. 1314 Hollins St.

Unknown ds.)

6 Years

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

## 6-DATE OF BIRTH.

Unknown

(Month)

(Day)

U.S. 45 (Year)

## 7-AGE,

77

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

## 9-BIRTHPLACE, (State or Country),

Ireland

## 10-NAME OF FATHER,

Michael Coyle

## 11-BIRTHPLACE OF FATHER (State or Country),

Ireland

## 12-MAIDEN NAME OF MOTHER

Unknown

## 13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John William

(Address)

1314 Hollins St.

## 15-

Filed

Robert P. Harrison,

191

Registrar.

1922

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Mch

15, 1922

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

May 20 1916 to Mch 15 1922

that I saw her alive on Mch 14 1922

and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH\* was as follows:

Epithelioma of Face

(Duration) 6 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) 6 yrs. mos. ds.

(Signed)

Henry C. O'Leary M.D.  
Mch 15, 1922 (Address) 1208 N. Fayette St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

New Cathedral Cem

## DATE OF BURIAL,

March 16 1922

## 20-UNDERTAKER

Robert Burko &amp; Son

## ADDRESS

Hollins St



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62416

## CERTIFICATE OF DEATH.

D 62416

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Motherhouse of Holy Name ST.; 10 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Geraldine Sullivan(Residence in Baltimore: No. Disque St. - Ashland Ave St.; 15 yrs.,    mos.    ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single  
(Write the word.)6-DATE OF BIRTH, June 11, 1864  
(Month) (Day) (Year)7-AGE, 57 yrs., 9 mos., 3 ds. If LESS than 1 day,    hrs. or    min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work Teacher  
(b) General nature of industry, business, or establishment in which employed (or employer)   9-BIRTHPLACE, (State or Country), South CarolinaPARENTS.  
10-NAME OF FATHER, Wm. J. Sullivan  
11-BIRTHPLACE OF FATHER (State or Country), S. Carolina  
12-MAIDEN NAME OF MOTHER, Elenora Burrage  
13-BIRTHPLACE OF MOTHER (State or Country), South Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister M. Brown(Address) Mother House Disque St.

15-

Filed Robert P. Harrison,  
1922 Registrar.

Burial Permit clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 14, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Jan. 18 1912, to Mar. 14 1912, that I saw her alive on Mar. 14 1912, and that death occurred, on the date stated above, at 4:50 p. m.The CAUSE OF DEATH\* was as follows:  
Chronic nephritis  
with acute exacerbation  
(Duration) 2 yrs.,    mos.,    ds.CONTRIBUTORY (Secondary)   (Signed) J. J. Kirby M. D.  
Mar. 15, 1922 (Address) 110 E. Lomb

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death    yrs.    mos.    ds. In the State    yrs.    mos.    ds.Where was disease contracted, if not at place of death?   Former or usual residence   19-PLACE OF BURIAL OR REMOVAL, Notchcliffe Mt. DATE OF BURIAL, Mar. 17, 192220-UNDERTAKER F. A. Pink ADDRESS 915 Gay



D 62417 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62417

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *110 N. Lincoln* ST., *6* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. *110 N. Lincoln*

(Usual place of abode)

Length of residence in city or town where death occurred *53* yrs. mos. ds.

ST., WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Julia Leines*6 DATE OF BIRTH (month, day, and year) *Unknown 1869*7 AGE Years *53* Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Lumber merchant*(b) General nature of industry, business, or establishment in which employed (or employer) *045*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balt*10 NAME OF FATHER *Not known*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Illus*12 MAIDEN NAME OF MOTHER *Not known*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Italy*

14

Informant (Address) *Julia Leines*

15

5 1922

*Robert P. Harrison*

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 14 1922*17 I HEREBY CERTIFY, That I attended deceased from *March 1*, 1922, to *March 14*, 1922that I last saw him alive on *March 14*, 1922.and that death occurred, on the date stated above, at *8* m.

The CAUSE OF DEATH\* was as follows:

*Diabetes Insipidus*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *14*(duration) yrs. mos. ds. *4*

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *Yes* Date of *March 14*Was there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *J. W. Harrison* M. D., 19 (Address) *22 N. Bond*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*New Baltimore* *March 16 1922*  
*Wendell Apple* *378 N. Bond*

Mack Steed

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62418

D 62418

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. *Front Royal Va.* ST. *3* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAR 16 1922

ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

March 11, 1922, to March 15, 1922,

that I last saw him alive on March 15, 1922,

and that death occurred, on the date stated above, at 7:30 p. m.

The CAUSE OF DEATH\* was as follows:

Ruptured gangrenous  
appendicitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *March 11 1922*Was there an autopsy? *yes*What test confirmed diagnosis? *Smear, Wright's, Gram's*

(Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 62419

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62419

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 S Street ST., 1 WARD)2-FULL NAME Bronisława Dobrowolski(a) RESIDENCE NO. 1112 S Street ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth Life yrs. — mos. — ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Child5a If married, widowed, or divorced HUSBAND of (or) WIFE of —6 DATE OF BIRTH (month, day, and year) Mar 2-19207 AGE Years 2 Months 12 Days 12 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none(b) General nature of industry, business, or establishment in which employed (or employer) —(c) Name of employer —9 BIRTHPLACE (city or town) Balto Md (State or country)10 NAME OF FATHER Anthony Dobrowolski11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)12 MAIDEN NAME OF MOTHER Stanisława Skrzyp13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)14 Informant Anthony Dobrowolski (Address) 1112 S Street15 MAR 16 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14 - 192217 I HEREBY CERTIFY, That I attended deceased from 3-14, 1922 to 3-14, 1922that I last saw him alive on 3-14, 1922and that death occurred, on the date stated above, at 8-30 m.

The CAUSE OF DEATH\* was as follows:

Pneumonia - Bronchitis(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted home if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Nathan Alexander M. D., 19 (Address) 3035 Odumville St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St. Stanislaus Cem 3-17 1922

20 UNDERTAKER

ADDRESS

Stephen Frankowski 1000 S. Pennsylvania

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*History of child  
having had measles  
before doctor was  
called.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

62420

## CERTIFICATE OF DEATH.

D 62420

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4103, Maine Ave ST. 28 WARD)

## 2-FULL NAME

Maisy Dean Bush

## (a) RESIDENCE NO.

4103 Maine Ave ST.

## WARD

(Usual place of abode)

Length of residence in city or town where death occurred

1 year

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Frances Deat Bush

## 6 DATE OF BIRTH (month, day, and year)

Apr 2, 1857

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

64

11

13

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Gen'l Supt 1886

(b) General nature of industry, business, or establishment in which employed (or employer)

Carnegie Steel

(c) Name of employer

Springfield Mass

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

David Bush.

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Mass.

## 12 MAIDEN NAME OF MOTHER

Miller

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Mass

## 14

Informant (Address)

Frances D Bush 4103 Maine Ave

## 15

MAR 16 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 15 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Mch. 3, 1922, to Mch. 15, 1922.

that I last saw him alive on Mch. 15, 1922.

and that death occurred, on the date stated above, at 11:45 A. M.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency

(duration)

yrs.

mos.

ds.

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. H. Stauchbury

M. D.

1922 (Address)

714 Park Ave/Bath St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

20m J. H. Stauchbury

North St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62421

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 N. Vincent ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Clarence Bagwell(Residence in Baltimore: No. 107 N. Vincent St.St.; yrs. 3 mos. 4 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE.

colored5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)  
Single

## 6-DATE OF BIRTH.

Dec 10, 1921  
(Month) (Day) (Year)

## 7-AGE.

3 yrs. 4 mos. 4 ds.

If LESS than 1 day,

....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

infant9-BIRTHPLACE,  
(State or Country).Balto. Md

## 10-NAME OF FATHER.

Levi Filler11-BIRTHPLACE OF FATHER  
(State or Country).Md.

## 12-MAIDEN NAME OF MOTHER

Gertrude Bagwell13-BIRTHPLACE OF MOTHER  
(State or Country).Va.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Mother

(Address).....

107 N. Vincent St.

## 15-

MAR 16 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

March 14, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

March 14 191 to March 14 191that I saw him alive on March 14 191and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH\* was as follows:

Primary  
Constitutional Syphilis  
(Primary)

(Duration)..... yrs. .... mos. .... ds.

CONTRIBUTORY  
(Secondary)Constitutional Syphilis

(Duration)..... yrs. .... mos. .... ds.

(Signed).....

Geo. E. Miller M. D.

....., 191... (Address).....

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 3 mos. 4 ds. In the State yrs. 3 mos. 4 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

St. John's ChurchMar 15, 1922

## 20-UNDERTAKER

## ADDRESS

Brown & Flanders114 W. Schenck St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62422

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

2

yrs.

ds.

How long in U. S., if of foreign birth?

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Walter Jones

6 DATE OF BIRTH (month, day, and year)

Unknown 1900

7 AGE

Years

Months

Days

If LESS than

22

Unknown

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Ann North Carolina

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Rose Westbank

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

North Carolina

14

Informant

Walter Jones

(Address)

2059 Woodberry Ave

15

MAR 16 1922

ROBERT B. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14 1922

17

I HEREBY CERTIFY, That I attended deceased from

Mar 7 1922, to Mar 14 1922,

that I last saw him alive on Mar 14 1922,

and that death occurred, on the date stated above, at 10:30 A. M.

The CAUSE OF DEATH\* was as follows:

Tobacco Poisoning  
(Myocardial Infarction)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. B. Bellish M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Ann North Carolina

March 17 1922

20 UNDERTAKER

ADDRESS

Chenoweth &amp; Co. Chestnut St.

D 62423 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62423

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *13* ST. *13* WARD)

2-FULL NAME

(a) RESIDENCE. No. *3065* Cedar Ave. ST. *13* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Albert H. Escott*

6 DATE OF BIRTH (month, day, and year) *Oct. 18, 1895*

7 AGE Years *26* Months *4* Days *27* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED *Telephone Operator*

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *md.*

10 NAME OF FATHER *Thomas Kilpatrick*

11 BIRTHPLACE OF FATHER (city or town) *md.* (State or country)

12 MAIDEN NAME OF MOTHER *Mary Marshall*

13 BIRTHPLACE OF MOTHER (city or town) *md.* (State or country)

14 Informant *Mercy Hospital Records* (Address)

15 Filed *MAR 16 1922* *ROBERT R. KRAUTER* Registrar *Burial Permit Clerk*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 15, 1922*

17 I HEREBY CERTIFY, That I attended deceased from *March 14, 1922* to *March 15, 1922* that I last saw her alive on *March 15, 1922* and that death occurred, on the date stated above, at *10:47 a.m.*

The CAUSE OF DEATH\* was as follows:

*Labar Pneumonia*

CONTRIBUTORY (Secondary) *Cardiac Failure* (duration) yrs. mos. ds. *1 1/2 hrs.*

18 Where was disease contracted *Home* if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *none*

What test confirmed diagnosis? *Signs & symptoms*

(Signature) *John J. Cronin* M. D.

(Address) *Mercy Hospital*

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Woodlawn Cem* *March 18, 1922*

20 UNDERTAKER ADDRESS

*Chenoweth & Son* *Chestnut, Pa*



D 62424

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 D 62424  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 645 Fulton Ave ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME Robert Barry Lethbridge

(a) RESIDENCE. NO. 645 Fulton Ave ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Wh. Ir.

5 Single, Married, Widowed,

or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Alice Lethbridge

6 DATE OF BIRTH July 16th 1848

7 AGE

73

7

Months

Days

If LESS than  
1 day, hrs.  
or min.

0

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

Real Estate

(c) Name of employer

James Keely

9 BIRTHPLACE (city or town) (State or country)

Brooklyn New York

10 NAME OF FATHER

Robert Lethbridge

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

England

12 MAIDEN NAME OF MOTHER

Catherine Barry

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Brooklyn New York

14

Informant  
(Address)H. A. Lethbridge  
1106 Continental Bldg

15

Filed

19

MAR 16 1922

ROBERT R. KRAUTER  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 16th 1922

1922

17

I HEREBY CERTIFY, That I attended deceased from

March 7th 1922, to March 16th 1922,

that I last saw him alive on March 16th 1922

and that death occurred, on the date stated above, at 3:30 a. m.

The CAUSE OF DEATH\* was as follows:

Coronary Atherosclerosis

(duration)

3 yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

Intestinal Infarction

(duration)

2 yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

H. A. Lethbridge M. D.

3/16/22 address)

401 E 25th St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Olivet

May 18/922

20 UNDERTAKER

ADDRESS

W. W. Cook 502 E 7th St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62425

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 East Saratoga WARD 12)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. — ds. How long in U. S., if of foreign birth? yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-12-19117 AGE Years 3 Months — Days — If LESS than 1 day, hrs. — or min. —

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md10 NAME OF FATHER Edward W. Green11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md12 MAIDEN NAME OF MOTHER Eloise M. Bell13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md14 Informant (Address) Eloise M. Green 418 E. Saratoga15 **MAR 16 1922** ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3, 15, 1922

17

I HEREBY CERTIFY, That I attended deceased from July 13, 1922 to Mich 15, 1922, that I last saw her alive on Mich 15, 1922, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH\* was as follows:

Lobar, Croupous Pneumonia(duration) yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary)

Cerebral involvement  
Convulsion  
(duration) yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? No

(Signed)

, 19 (Address)

Henry J. Jorgensen, M. D.  
424 E. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Forrester & Son  
William Cook3/17 1922  
502 E. North

Dr. Owen

Fairbank + Potomac Ave.

D 62426

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 N. Linwood ST. WARD)

2. FULL NAME Millard Filmore Thomas

(a) RESIDENCE NO. 410 N. Linwood ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of  
or WIFE of

Bertha Lee Thomas

6 DATE OF BIRTH (month, day, and year) Sep-26-1856

7 AGE Years 65- Months 5- Days 16 If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Printer 063

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt-

10 NAME OF FATHER Henry Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER Leah Pickens

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14 Informant Bertha Lee Thomas (Address) 410 N. Linwood

15 MAR 16 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1922

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1922, to March 14, 1922,

that I last saw him alive on March 14, 1922,

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH\* was as follows:

Cerebral - Hemorrhage

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John F. Owen M. D.

(Address) 35 N. Potomac St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt. Olivet

20 UNDERTAKER

H. M. Cook

DATE OF BURIAL

March 17 1922

ADDRESS

410 N. Linwood

D 62427

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

D 62427

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 N. Mount St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Brown Tracy

(Residence in Baltimore: No. 223 N Mount St.) St.; 7 yrs., 8 mos. - ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

Write the word.

Married

6-DATE OF BIRTH,

July 23, 1858

(Month)

(Day)

(Year)

7-AGE,

63

7 yrs., 21 mos., 21 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Salesman for

(b) General nature of industry, business, or establishment in which employed (or employer).

Rel. Literature

9-BIRTHPLACE,

(State or Country),

Penn.

10-NAME OF FATHER,

Jeremiah Tracy

11-BIRTHPLACE OF FATHER,

(State or Country),

?

12-MAIDEN NAME OF MOTHER,

Elizabeth Taylor

13-BIRTHPLACE OF MOTHER,

(State or Country),

T.J.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. N. Sisco

(Address) 1315 N. Chase St.

MAR 16 1922

ROBERT R. KRAUTER,

Filed

191

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 14, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

mch. 11, 1922, to mch. 14, 1922,

that I saw him alive on mch. 14, 1922,

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH\* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. N. Sisco M. D.

mch. 15, 191... (Address) 1315 N. Chase St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Crumpton, Md. 3/17/1922

20-UNDERTAKER

ADDRESS

Wm Cook, 502 G. North ave.



D 62428 HEALTH DEPARTMENT—CITY OF BALTIMORE 62428

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 15227 Bruce ST. 15 WARD) 179

REGISTERED NO. ....  
(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## 2-FULL NAME

(a) RESIDENCE, No. 15-227 Bruce ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Winston Ballard

6 DATE OF BIRTH (month, day, and year) 2-22-1863

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
5-9 — 19

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

MAR 16 1922

ROBERT R. KRAUTER,

Bureau Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-13 1922

17 I HEREBY CERTIFY, That I attended deceased from  
3-11, 1922, to 3-13, 1922,

that I last saw him alive on 3-13, 1922,

and that death occurred, on the date stated above, at 6:15 p. m.

The CAUSE OF DEATH\* was as follows:

Chronic ~~interstitial~~ interstitial nephritis  
about 2 yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George C. Page M. D.

19 (Address) 17207 Mount St.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn Cemetery

Mar. 16, 1922

20 UNDERTAKER

ADDRESS 1203

James H. Damm

Baltimore

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62429

## CERTIFICATE OF DEATH.

D 62429

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2016 McCallish WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, .... hrs.  
or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

MAR 16 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
Feb. 18, 1922, to March 13, 1922.

that I last saw him live on March 13, 1922.

and that death occurred, on the date stated above, 12:40 P.M.

The CAUSE OF DEATH\* was as follows:

Autogenous  
due to cancer  
of the breast  
(duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? for Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. L. E. M. D.

, 19 (Address) 927 Anderson

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 62430

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62430

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No.

Lombard &amp; Inner st

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William B. Bond

(a) RESIDENCE, NO.

2015 Edgewood St

ST.:

WARD.

Resident

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

45 yrs. 6 mos. 12 ds.

How long in U. S., if of foreign birth? 45 yrs. 6 mos. 12 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Mary E. Bond

6 DATE OF BIRTH (month, day, and year)

1876 Sep-3

7 AGE

Years

Months

Days

If LESS than  
1 day, hr.  
or min.

45

6

12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

Automobile

(c) Name of employer

Motor Car Co

9 BIRTHPLACE (city or town).  
(State or country)

Baltimore Md.

10 NAME OF FATHER

Viggo Bond

11 BIRTHPLACE OF FATHER (city or town)

Md.

(State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Mary Petros.

13 BIRTHPLACE OF MOTHER (city or town)

Baltimore

(State or country)

Md.

14

Informant  
(Address)Mrs Mary E. Bond - (wife)  
2015 Edgewood St.

15

File

MAR 16 1922

ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/15 1922

17

I HEREBY CERTIFY, That I attended deceased from

3/9/1922, to 3/15/1922,

that I last saw him alive on 3/15/22, 1922.

and that death occurred, on the date stated above, at 1:20 P. m.

The CAUSE OF DEATH\* was as follows:

Tuberculous Meningitis - own  
Acute Miliary Tuberculosis.

(duration) yrs. mos. 21 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy findings

(Signed) J. J. Jones, M. D.

7/15, 1922 Address) Green Mount Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Green Mount Cemetery

May 17/1922

20 UNDERTAKER

STEWART &amp; MOWEN COMPANY

ADDRESS

(WILLIAM F. WOODEN, Successor)

108 W. NORTH AVE.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on, may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No record in Nursing  
Division*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62431 DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. *M/4 E. Federal* ST., *8* WARD2-FULL NAME *Mrs. F. Kuzmanoff*(a) RESIDENCE No. *M/4 E. Federal* ST., *8* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *1 yr.* yrs. *0* mos. *0* ds.How long in U. S., if of foreign birth? *1 yr.* yrs. *0* mos. *0* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*4 COLOR OR RACE *N*5 Single, Married, Widowed, or Divorced, (write the word) *married*

5a If married, widowed, or divorced

HUSBAND of *Minnie Kuzmanoff*  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *July 7, 1865*

7 AGE

Years

Months

Days

If LESS than  
✓ day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Carpenter*(b) General nature of industry, business, or establishment in which employed (or employer) *015*

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto*  
(State or country) *and*10 NAME OF FATHER *M. Kuzmanoff*11 BIRTHPLACE OF FATHER (city or town) *Balto*  
(State or country) *and*12 MAIDEN NAME OF MOTHER *May Thelen*13 BIRTHPLACE OF MOTHER (city or town) *Balto*  
(State or country) *and*

14

Informant *Minnie C. Kuzmanoff*  
(Address) *M/4 E. Federal St.*

15

MAR 16 1922

Registrar *[Signature]*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 14, 22*

17

I HEREBY CERTIFY, That I attended deceased from *Dec 14, 1921* to *Mar 14, 1922*  
(that I last saw him live on *Mar 14, 1922*)and that death occurred, on the date stated above, at *100* m.

The CAUSE OF DEATH\* was as follows:

*Cursing of Nephew  
involving Strang*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary) *asthma*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death? *unknown*Did an operation precede death? *No*Date of *No*Was there an autopsy? *No*What test confirmed diagnosis? *findings*(Signed) *[Signature]*

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL *St. Mary's*

DATE OF BURIAL

*May 17, 22*20 UNDERTAKER *Robt. Thomas*ADDRESS *100 N. 1st St.*

D 62432

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62432

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 E. Hamburg ST.: 24 WARD)REGISTERED NO. ....  
(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## 2-FULL NAME

Edward L Lang(a) RESIDENCE. No. 205 E. Hamburg ST.: 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 3 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed,  
or Divorced (write the word) Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Mar 20 19097 AGE Years 13 Months 3 Days 24 If LESS than  
1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work School boy(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) Baltimore

## 10 NAME OF FATHER

Charles L. Lang11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Baltimore

## 12 MAIDEN NAME OF MOTHER

Margaret Kelly13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Baltimore

14

Informant  
(Address) Mrs. Margaret Kelly  
205 E. Hamburg

15

Filed

MAR 16 1922

19

Registrar ELG

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16 1922

17

I HEREBY CERTIFY, That I attended deceased from  
Mar 15, 1922, to Mar 16, 1922.that I last saw him alive on Mar 15, 1922.and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH\* was as follows:

Diphtheria(duration) yrs. mos. 2 ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Alumina(Signed) W. H. Campbell M. D.19 (Address) 1644 Hanover St.\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

1644 Hanover St. Baltimore

20 UNDERTAKER

ADDRESS

W. H. Campbell

HEALTH DEPARTMENT—CITY OF BALTIMORE **D 62433**

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *100 Battery Ave* ST.: *2nd* WARD)2-FULL NAME *Irene Horton*(a) RESIDENCE. NO. *900 Battery Ave* ST.: *2nd* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *2* yrs. *3* mos. *25* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Mar 13, 1920*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*2**25*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *Charles Horton*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore*12 MAIDEN NAME OF MOTHER *Elizabeth Horton*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore*

14

Informant (Address) *Clarence Horton 900 Battery Ave*

15

Filing **MAR 16 1922**Registrar *LL*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 15 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar 13 1922 to Mar 15 1922*that I last saw him alive on *Mar 14 1922*and that death occurred, on the date stated above, at *1 A* m.

The CAUSE OF DEATH\* was as follows:

*Broncho Pneumonia*(duration) yrs. mos. *12* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *1* ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Chemically*Signed *R. H. Campbell* D.U. S. 1922 (Address) *1644 Hancock St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Bedford Hill Cemetery Mar 17 1922*

20 UNDERTAKER

ADDRESS

*Wm. C. Campbell 1644 Hancock St*

D 62434

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 530 S. Bentalow ST., 2nd WARD)2-FULL NAME Ellen Ruth Appel(a) RESIDENCE NO. 530 S. Bentalow ST., 2nd WARD

(Usual place of abode)

Length of residence in city or town where death occurred

— yrs. 9 mos. 7 ds.

How long in U. S., if of foreign birth? — yrs. — mos. — ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female WhiteSingle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7th 1911

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

— 9 7

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.10 NAME OF FATHER Joseph E. Appel11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.12 MAIDEN NAME OF MOTHER Esther F. Schaff13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14

Informant (Address) Joseph E. Appel  
530 S. Bentalow St.

15

Filed

19

MAR 16 1922

Registrar E. G. G.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 192217 I HEREBY CERTIFY, That I attended deceased from February 28, 1922, to March 14, 1922, that I last saw her alive on March 14, 1922, and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia(duration) — yrs. — mos. 14 ds.CONTRIBUTORY (Secondary) Pulmonary edemaEndocarditis (duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C. Nichol, M. D.3/19/22 (Address) 2151 Milburn Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Landon Park CemeteryDATE OF BURIAL Mar 17 192220 UNDERTAKER A. B. HeppertADDRESS 2236 E. 1st Ave



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Houskeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior*  
*Endocarditis acute*

D 62435

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 62435

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital.ST.: 76 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Brady(a) RESIDENCE. NO. Unknown unknown ST. --- WARD. ---  
(Usual place of abode)Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.  
(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of ---6 DATE OF BIRTH (month, day, and year) 18787 AGE Years 43 Months -- Days -- If LESS than 1 day, hrs. --- or min. ---

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland  
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown  
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)14 Informant Hospital Records,  
(Address) Municipal Hospital.15 Filed MAR 16 1922 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 192217 I HEREBY CERTIFY, That I attended deceased from March 12, 1922, to March 13, 1922, that I last saw him alive on March 12, 1922, and that death occurred, on the date stated above, at 12:45 AM

The CAUSE OF DEATH\* was as follows:

Chronic nephritis(duration) 5 yrs. mos. ds.CONTRIBUTORY Chemia  
(Secondary)(duration) 5 yrs. mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? ---

What test confirmed diagnosis?

(Signed) Clyde McNeill M. D.3/13/22 Address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St Patrick Cemetery March 16 1922

20 UNDERTAKER

ADDRESS

Mr. Much S. Brier 1808 N. Brady

D 62436

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62436

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE No. 823 Powers St. ST. 13 WARD

## 2-FULL NAME

Frances J. Abbott

(a) RESIDENCE No.

823 Powers St.

ST. 13

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced, (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 16-1922

7 AGE

Years

Months

Days

If LESS than  
1 day, 2 hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

At Home

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Balto.  
Maryland

10 NAME OF FATHER

Albert H. Abbott

11 BIRTHPLACE OF FATHER (city or town)

Carroll Co

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Anna Harding

13 BIRTHPLACE OF MOTHER (city or town)

Balto.

(State or country)

Maryland

14

Informant

(Address)

Albert H. Abbott  
823 Powers St.

15

MAR 16 1922

J. W. Helm

Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 16 1922

17

I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred, on the date stated above, at 5:05 A. m.

The CAUSE OF DEATH\* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

1916, 1922 (Address) 3449 Chestnut St

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Greenmount (Carroll Co) Md. March 16 1922

20 UNDERTAKER

ADDRESS

Horace H. Burgee

363 Fall Rd





## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62438

D 62438

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 15

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,

or Divorced (write the word)

6a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 12, 1922, to March 15, 1922.

that I last saw her alive on March 15, 1922.

and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH\* was as follows:

Child birth, Term  
Pregnancy membranes ruptured  
4 hrs before delivery of a  
still-born babyCONTRIBUTORY Puerperal infection, Septicemia  
(Secondary) duration 1 mos 3 ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? Home  
Date of operation precede death? Feb 12/1922

Was there an autopsy? No

What test confirmed diagnosis? Autopsy, signs of Septicemia

(Signed) John J. Edson, M. D.

19 (Address) Mercy Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Nehru Nash Road

3/16/22

20 UNDERTAKER

ADDRESS

Joek Lewis 1434 9th Ave

MAR 16 1922

ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk

D 62439

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED.

(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

MAR 16 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I have charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)

(Signed)

(Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs... mos... ds. In the State... yrs... mos... ds.

Where was disease contracted, if not at place of death?....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62440

## CERTIFICATE OF DEATH.

D 62440

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 Sargeant ST. 21 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Perry Harp(a) RESIDENCE. NO. 21 Sargeant ST. 21 WARD.(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred 58 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced  
HUSBAND of Martha U. Harp  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) May 30, 18507 AGE Years 71 Months 9 Days 15 If LESS than 1 day, hrs. — or min. —

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pipe Fitter(b) General nature of industry, business, or establishment in which employed (or employer) 059

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co  
(State or country) md10 NAME OF FATHER Perry G. Harp11 BIRTHPLACE OF FATHER (city or town) Carroll Co  
(State or country) md12 MAIDEN NAME OF MOTHER Charlotte Jenkins13 BIRTHPLACE OF MOTHER (city or town) Carroll Co  
(State or country) md14 Informant Howard Carlton Harp  
(Address) 1211 Sargeant St15 Filed Robert P. Harrison, Registrar

6 1922 Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 15 19 2217 I HEREBY CERTIFY, That I attended deceased from James, 19 22, to Mar 15, 19 22,  
that I last saw him alive on Mar 15, 19 22,  
and that death occurred, on the date stated above, at 9 P. m.  
The CAUSE OF DEATH\* was as follows:Chronic Interlobar Nephritis  
(duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted  
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyd, M. D.(Address) 602 Calumet Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodson Park DATE OF BURIAL 3/18 19 2220 UNDERTAKER George J. Smith ADDRESS 1000 N. Fayette St

D 62441

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62441

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 S. WolfeST.: V WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Novak(a) RESIDENCE. NO. 713 S. Wolfe

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of)

Mary Novak6 DATE OF BIRTH (month, day, and year) Unknown 18937 AGE 49 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

161922

19 Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/14/1922

17

I HEREBY CERTIFY, That I attended deceased from December, 1921, to March 14, 1922, that I last saw him alive on March 14, 1922, and that death occurred, on the date stated above, at 9 P. m. The CAUSE OF DEATH\* was as follows:Nephritis (Chronic Interstitial)  
Chronic Myocarditis(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical & Laboratory(Signed) Philibert Artigiani, M. D., 19 (Address) 2942 E. Fayette St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy RosaryMarch 18 19

20 UNDERTAKER

ADDRESS

Jacob Fialkowski428 S. Bond



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62442

D 62442

## CERTIFICATE OF DEATH.

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. *MD 928* ST. *16* WARD)

## 2-FULL NAME

*William H. Godfrey*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE. NO.

*928 Gilmore*ST. *16* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *52* yrs. *6* mos. *24* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*M*

## 4 COLOR OR RACE

*W*

## 5 Single, Married, Widowed, or Divorced (write the word)

*M*

## 5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

*Mrs. Jennie Godfrey*

## 6 DATE OF BIRTH (month, day, and year)

*Aug 25-1869*

## 7 AGE

*52*

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*6 24*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Plumber*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Balto*

## 10 NAME OF FATHER

*John H. Godfrey*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ireland*

## 12 MAIDEN NAME OF MOTHER

*Betty G. H.*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ireland*

## 14

Informant

(Address)

*Jennie C. Godfrey 928 N. Gilmore*

## 15

Filed

*Robert P. Harrison, Registrar*

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*Mar 16 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*2/15/22*, 19, to *2/16/22*, 19that I last saw him alive on *2/16/22*, 19and that death occurred, on the date stated above, at *6 12* m.

The CAUSE OF DEATH\* was as follows:

*Arteriosclerosis*(duration) yrs. mos. ds. *3*

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *3*

## 18 Where was disease contracted?

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Chas. H. Hays*, M. D., 19 (Address) *1201 N. Fayette St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Baltimore Cemetery**Mar 18 1922*

## 20 UNDERTAKER

## ADDRESS

*John Ottatell 1201 N. Fayette St.*

D 62443

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62443

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

Lifetime

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

March 12, 1922, to March 15, 1922,

that I last saw her alive on March 15, 1922,

and that death occurred, on the date stated above, at 11:05 A. M.

The CAUSE OF DEATH\* was as follows:

Carbuncle of upper and lower lip.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) General Septicemia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 3/12/22

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture

(Signed) J. M. Humey, M. D.

3/15, 1922 (Address) Union Memorial Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 62444

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62444

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Favor &amp; Green

ST.:

WARD)

2-FULL NAME

Christina Greller

(a) RESIDENCE, No.

Kenwood Ave

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

(or) WIFE of

Andrew Greller

6 DATE OF BIRTH (month, day, and year)

Sept. 27-

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Germany

10 NAME OF FATHER

Schroeder Wittenberg

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Veronica Goldberg

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant

(Address)

Andrew Greller  
Kenwood Ave, Baltimore

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-14-22

17

I HEREBY CERTIFY, That I attended deceased from

3-13-22 to 3-14-22

that I last saw her alive on 3-14-22

and that death occurred, on the date stated above, at 6:15 A. M.

The CAUSE OF DEATH\* was as follows:

Intestinal obstruction

(duration)

yrs.

mos.

2 ds.

CONTRIBUTORY (Secondary)

Myocardial Infarction

(duration)

yrs.

mos.

6 mos.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 3-13-22

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Cyrus D. Hume, M. D.

, 19 (Address) University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Cem.

Mch 17 1922

20 UNDERTAKER

ADDRESS

Lilly E. Zieher

403 S. Wolfe

1922

D 62445

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1716 Osborne ST., 19 WARD)2. FULL NAME George Coates(a) RESIDENCE NO. 1716 Osborne St

(Usual place of abode)

ST.,

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 1 yrs. 0 mos. 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE Col5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 15 21

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 1 yr.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work for

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country)10 NAME OF FATHER John Coates11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country)12 MAIDEN NAME OF MOTHER Esther Rice13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country)

14

Informant (Address) John Coates  
1716 Osborne St

15

Robert P. Hart 1902,

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16 1922

17

I HEREBY CERTIFY, That I attended deceased from

Mar 11, 1922, to Mar 13, 1922.that I last saw him alive on Mar 15, 1922.and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH\* was as follows:

Capillary  
bronchitis  
over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benjamin H. Smith, M. D.1922 (Address) 1714 Pennsylvania

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Auburn3/18/22

20 UNDERTAKER

ADDRESS

Samuel H. Chace1400 N. St

6 1922



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN,

*No other infection*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62446

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 Valley View Ave. Baltimore)

2-FULL NAME Irene M. Thomas

(a) RESIDENCE NO. 213 Valley View Ave. Baltimore

(Usual place of abode)

Length of residence in city or town where death occurred: Life mos. ds. How long in U. S., if of foreign birth: Life yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 25/22

7 AGE Years Months Days If LESS than 1 day, hrs or min. 10

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

10 NAME OF FATHER Robert B. Thomas

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Margaretta Thomas

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Robert B. Thomas (Address) 213 Valley View Ave.

15 Filed 1922 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1922

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1922, to March 14, 1922, that I last saw h. alive on March 14th, 1922, and that death occurred, on the date stated above, at 6 30 m. The CAUSE OF DEATH\* was as follows: S. Pneumonia.

CONTRIBUTORY (Secondary)

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Surtan A. Fritz, M. D. 3/15, 1922 (Address) Oakland

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

William Baker &amp; Son

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Lobar pneumonia*  
*Primary*

D 62447

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

11 D 62447

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Mill Race Road 3 WARD)

## 2-FULL NAME

Lillie E. Varie

## (a) RESIDENCE NO.

1416 Mill Race Road

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)

F

W.

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1860.

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

62

11

16

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Mill hand

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

James R. Varie

PARENTS

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

Annie Carter

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)Hannor Varie  
1416 Mill Race Road.

15

6 1922

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 15-1922

17

I HEREBY CERTIFY, That I attended deceased from

March 8th, 1922, to March 15th, 1922,

that I last saw him alive on March 14th, 1922,

and that death occurred, on the date stated above, at 9 A. M.

The CAUSE OF DEATH\* was as follows:

Suicide by hanging.

(duration) yrs. mos. 7. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. E. Lillie, M. D.

3/15, 1922

(Address) 1527 Union Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

St. Mary's Hospital

20 UNDERTAKER

J. M. Cook

DATE OF BURIAL

March 17, 1922

ADDRESS

N. B. AGO



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62448

## CERTIFICATE OF DEATH.

10 D 62448

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital* ST. WARD)2-FULL NAME *Wilburn Foster.*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. *2722 Hampden Ave.* ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred *2* yrs. *9* mos. *16* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *single.*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *June 29-1919*7 AGE Years *2* Months *9* Days *16* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto.*  
(State or country) *md.*10 NAME OF FATHER *Harry Foster.*11 BIRTHPLACE OF FATHER (city or town) *Balto.*  
(State or country) *md.*12 MAIDEN NAME OF MOTHER *Anna Willand*13 BIRTHPLACE OF MOTHER (city or town) *Balto.*  
(State or country) *md.*14 Informant *John Willand*  
(Address) *2636 Hampden Ave.*15 Filed *Robert P. Harrison,* Registrar

6 1922 Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 16 1922*17 I HEREBY CERTIFY, That I attended deceased from *Feb. 8*, 19*22*, to *March 16*, 19*22*, that I last saw him alive on *March 16*, 19*22*, and that death occurred, on the date stated above, at *9:30 a. m.*

The CAUSE OF DEATH\* was as follows:

*Diphtheria - tonsillar,*  
*pharyngeal + laryngeal*  
(duration) *1* yrs. *7* mos. *7* ds.CONTRIBUTORY *acute myocarditis.*  
(Secondary) (duration) yrs. *1* mos. *7* ds.18 Where was disease contracted *at home*  
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *cultures positive*  
(Signed) *B. M. Gowan*, M. D.3/16/1922 (Address) *Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Baltimore Cemetery* *3-17 1922*

20 UNDERTAKER ADDRESS

*William Cook* *502 E. North Ave.*

D 62449

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62449

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

1922

Burial Permit Clerk

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, that I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

find that said deceased came to his death

of the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER,

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62450

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Shakspeare ST., 2 WARD)

2. FULL NAME JOSEPH A. BIERNACKI,

(a) RESIDENCE No. 1604 Shakspeare

(Usual place of abode)

ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 0) yrs. 0 mos. I ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male, 4 COLOR OR RACE White, 5 Single, Married, Widowed, or Divorced, (write the word) S. \*\*\*\*\*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15, 1922.

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 0 0 I

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None, ood

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md., (State or country)

10 NAME OF FATHER Casimir Biernacki,

11 BIRTHPLACE OF FATHER (city or town) Poland, (State or country)

12 MAIDEN NAME OF MOTHER Mary Gadowska,

13 BIRTHPLACE OF MOTHER (city or town) Poland, (State or country)

14 Informant Casimir Biernacki, (Address) 4 1604 Shakspeare Street

15 MAR 17 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MARCH 16- 19 22.

17 I HEREBY CERTIFY that I attended deceased from March 16, 19 22 to March 16, 19 22 that I last saw him alive on March 16, 19 22

and that death occurred, on the date stated above, at 7.00 A- m.

The CAUSE OF DEATH\* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? nu

Did an operation precede death? nu Date of

Was there an autopsy? nu

What test confirmed diagnosis?

(Signed) J. H. Williams, M. D. 3/17/22 (Address) 801 E. Lexington

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Stanislaus.

Mar. 17, 1922.

20 UNDERTAKER

ADDRESS

M. J. Sadowski.

705 S. Ann St.

D 62451 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 62451

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 104 W. York Street. St. 22 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Lewis W. Moore. (C).

(Residence in Baltimore: No. 104 W. York Street. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, Colored. 5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

6-DATE OF BIRTH, Do not know. (Month) (Day) (Year)

7-AGE, 36 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Virginia.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER, (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Jones. (C).

(Address) 104 W. York Street.

15-ROBERT R. KRAUTER,

Filed MAR 17 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 7th. 1922. (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cobar Pneumonia.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. R. Reinhard M. D. (Coroner.)

Mar. 14. 1922. (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, HOPKINS HOSPITAL

DATE OF BURIAL

MAR 16 1922

20-UNDERTAKER, Commissioner Health.

ADDRESS

Morgue



# HEALTH DEPARTMENT—CITY OF BALTIMORE

62452

## CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1500* St. *W* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1750* Easton Ave

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH, *Mar 1, 1862*  
(Month) (Day) (Year)

7-AGE, *60* yrs. mos. ds. If LESS than 1 day, ....hrs. or....min.

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work *Housework*  
(b) General nature of industry, business, or establishment in which employed (or employer) *600*

9-BIRTHPLACE, (State or Country), *Germany*

10-NAME OF FATHER, *Henry Schmidt*

11-BIRTHPLACE OF FATHER (State or Country), *Ger*

12-MAIDEN NAME OF MOTHER *Maria S Fritz*

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr R. Bierback*

(Address) *Brhms Lane*

15-

MAR 17 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk,

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Mar 16, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said... (Inquest, au-

topsy or inquiry.) and that said deceased came to... death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Cerebral*  
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (Duration) ....yrs. ....mos. ....ds.

(Signed) *W. H. M. D.* (Coroner) *5-19, 1922* (Address) *4 S. ...*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ....mos. ....ds. In the State... yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Mt Carmel* DATE OF BURIAL, *Mar 17, 1922*

20-UNDERTAKER *Peter Nicolaus* ADDRESS *2046 Easton*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62453

## CERTIFICATE OF DEATH.

129 D 62453

## 1-PLACE OF DEATH

CITY OF BALTIMORE; No. 1829 Druid Hill av ST.: 14 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E. Barrett

(a) RESIDENCE. No. 1829 Druid Hill av ST. (Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE C 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE 63 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler 070

(b) General nature of industry, business, or establishment in which employed (or employer) Private waiter

(c) Name of employer

9 BIRTHPLACE (city or town) Md. (State or country)

10 NAME OF FATHER William Barrett

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Sarah Riley

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Laura V. Barrett (Address) 1829 Druid Hill av

15 MAR 17 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 1 - 1922, to Mar 14, 1922,

that I last saw him alive on Mar 14, 1922,

and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH\* was as follows:

Cardiac insufficiency, (De compensation), over

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis: Hypertension

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Pressure test

(Signed) Edw Short M. D.

3/16/22 (Address) 1812 Druid Hill av

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Lanier Cemetery

DATE OF BURIAL

Mar 17 1922

20 UNDERTAKER

Jno. M. Johnson

ADDRESS 1234

E. M. Johnson

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Probably chronic  
nephritis.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62454

## CERTIFICATE OF DEATH.

D 62454

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Waltham St. ST. 10 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Alice Mohr(Residence in Baltimore: No. Waltham St. St.; yrs. 4 mos. 4 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Female</u>	4-COLOR OR RACE. <u>White</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <u>Single</u> (Write the word.)
-------------------------	----------------------------------	--

6-DATE OF BIRTH.  
March 15, 1892  
(Month) (Day) (Year)7-AGE,  
30 yrs. 1 mos. 1 ds.  
If LESS than 1 day, ...hrs. or ...min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work... Music Teacher  
(b) General nature of industry, business, or establishment in which employed (or employer)... 0869-BIRTHPLACE,  
(State or Country), New York N.Y.

PARENTS.	10-NAME OF FATHER, <u>William Mohr</u>
	11-BIRTHPLACE OF FATHER (State or Country), <u>Germany</u>
	12-MAIDEN NAME OF MOTHER <u>Kunigunde Loch</u>
	13-BIRTHPLACE OF MOTHER (State or Country), <u>Germany</u>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. Mary W. W. W.(Address) Waltham St. 10

15-

Filed **MAR 17 1922** **ROBERT R. KRAUTER,**  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,  
March 16, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from  
March 12, 1922, to March 16, 1922,  
that I saw her alive on March 12, 1922,  
and that death occurred, on the date stated above, at 8:30 m.The CAUSE OF DEATH\* was as follows:  
Asphyxia  
and Pneumonia  
(Duration) ... yrs. ... mos. 4 ds.CONTRIBUTORY  
(Secondary)  
(Duration) ... yrs. ... mos. ... ds.(Signed) F. J. Kearley M. D.  
3/16, 1922 (Address) 1108 W. 10th St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence N.Y.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Notch Cliff Rd March 18, 1922

20-UNDERTAKER ADDRESS

Frank A. Kirk 915 N. Gay St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62455

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3720 Roland Ave. 13 WARD)

## 2-FULL NAME

(a) RESIDENCE. NO. 3720 Roland

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. 4 ds. How long in U. S., if of foreign birth? 70 yrs. mos. 4 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of

(or WIFE of)

Mary E. Foyle

6 DATE OF BIRTH (month, day, and year)

May 11-1882

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

70

4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

Railroad

(c) Name of employer

Penn. R. R.

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Charles L. Foyle

11 BIRTHPLACE OF FATHER (city or town)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

Germany

14

Informant

(Address)

Guy Foyle 3720 Roland Ave

15

MAY 17 1922

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 21, 1921, to May 15, 1922

that I last saw him alive on May 15, 1922

and that death occurred, on the date stated above, at 1:15 P. M.

The CAUSE OF DEATH\* was as follows:

Aortic Insufficiency

(duration)

2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration)

1 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Physical signs

(Signed) C. Houghlin M. D.

216 192 (Address) 3720 Roland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

New Cathedral May 18 1922

20 UNDERTAKER

ADDRESS

A. S. Marshall 5539 Fall Rd

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

No terminal hemorrhage  
Not luetic.  
Paralysis

D 62456

HEALTH DEPARTMENT - CITY OF BALTIMORE

D 62456

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 E. Baltimore St. ST., 3 WARD)

## 2. FULL NAME

Ellis Krivitzky(a) RESIDENCE NO. 1117 E. Baltimore St.

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds.

ST., WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 32 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

White M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Rose Krivitzky

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

72 - -

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Pacey Krivitzky

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant (Address)

J. Lewis 1439 E. Baltimore St.

15

MAR 17 1922

ROBERT R. KRAHMER

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17 19 2217 I HEREBY CERTIFY, That I attended deceased from 3/17 19 22 to 3/17 19 22that I last saw her alive on 3/17 19 22 at 250 A m.

and that death occurred, on the date stated above, at The CAUSE OF DEATH\* was as follows:

Pulver Tuberculosis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical

(Signed)

3/17, 1922 Address) 210 Red Jacket

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

John Rosedale 3-17 1922  
Jack Lewis 1439 E. Baltimore St.

D 62457

HEALTH DEPARTMENT—CITY OF BALTIMORE

62457

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE (No.

730 Poplar Grove St. 16

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

August F. Haerlein

(Residence in Baltimore: No.

730 Poplar Grove St.

St.; yrs., 18 mos. 10 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

male white

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

single

6-DATE OF BIRTH,

Sep. 15, 1920

(Month) (Day) (Year)

7-AGE,

1 yrs. 4 mos. 10 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).unemp 800  
(Unemployed)

9-BIRTHPLACE, (State or Country),

Balto. Md.

10-NAME OF FATHER,

Aug. F. Haerlein

11-BIRTHPLACE OF FATHER (State or Country),

Balto. Md.

12-MAIDEN NAME OF MOTHER

Eva Regu

13-BIRTHPLACE OF MOTHER (State or Country),

Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Aug. F. Haerlein

(Address)

730 Poplar Grove St.

15-

Filed

MAR 17 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

March 14, 1922

(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Pneumo-pneumonia

(Duration) yrs. mos. ds. 5

CONTRIBUTORY (Secondary)

no history of any infectious disease

(Duration) yrs. mos. ds.

(Signed) J. E. Haerlein, M. D.

(Coroner.)

March 16, 1922 (Address) 2802 E. Baltimore Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

Baltimore Cen

3/18, 1922

20-UNDERTAKER

ADDRESS

J. F. McCall

130 E. Fort



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62458

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 11

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No.

St.; 2 yrs., — mos. — ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE.

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

married

## 6-DATE OF BIRTH,

....., 1.....  
(Month) (Day) (Year)

## 7-AGE,

69

yrs. .... mos. .... ds.

If LESS than 1 day,

.... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Housewife

Housewife

## 9-BIRTHPLACE,

(State or Country),

North Carolina

## 10-NAME OF FATHER,

Henderson Mackey

## 11-BIRTHPLACE OF FATHER

(State or Country), born in D.C.

## 12-MAIDEN NAME OF MOTHER

Unknown

## 13-BIRTHPLACE OF MOTHER

(State or Country), Unknown

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Carman

(Address)

909 McCulloch St.

15-

Filed

191

ROBERT R. KRAUTER,

Burial Permit Clerk

MAR 17 1922

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

..... 3..... 15, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Feb 14 1922, to Mar 15 1922

that I saw her alive on Mar 13 1922

and that death occurred, on the date stated above, at 12:05 p.m.

The CAUSE OF DEATH\* was as follows:

..... Hemiplegia

..... (Duration)..... yrs. .... mos. .... ds.

## CONTRIBUTORY (Secondary)

..... (Duration)..... yrs. .... mos. .... ds.

(Signed)..... M. D.

3-14-22, 1912 (Address) 1307 Hill Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19-PLACE OF BURIAL OR REMOVAL,

Northern N.C.

## DATE OF BURIAL,

March 18 1922

## 20-UNDERTAKER

Mrs Robert A Elliott Ashland Va

## ADDRESS

1725

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62459

## CERTIFICATE OF DEATH.

160 D 62459

## 1-PLACE OF DEATH

CITY OF BALTIMORE; NO.

ST. 7 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

## (a) RESIDENCE. NO.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 9 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

May 24, 1921

## 7 AGE

Years 9 Months 24 Days

LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

## 10 NAME OF FATHER

John D. Cook

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

## 12 MAIDEN NAME OF MOTHER

Ann E. Williams

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

## 14

Informant (Address)

John D. Cook  
1818 Beech St

## 15

MAR 17 1922

ROBERT R. KRAUTER  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3, 17 1922

17

I HEREBY CERTIFY, That I attended deceased from

3, 14 1922, to 3, 17 1922

that I last saw him alive on 3, 17 1922

and that death occurred, on the date stated above, at 2:40 a.m.

The CAUSE OF DEATH\* was as follows:

Convulsions

## CONTRIBUTORY (Secondary)

(duration) 3 hours  
Gen anemia from birth

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. J. Durrington, M. D.

, 19 (Address) 102 E. Fort St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Mt Carmel Cem

May 18 1922

## 20 UNDERTAKER

## ADDRESS

J. J. Hogan & Son  
447 Howard StJ. J. Hogan & Son  
447 Howard St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 62460

D 62460

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Belvidere ave Lakeland* ST.; *25* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Sonnetty Marie Hinks*

(Residence in Baltimore: No. *Belvidere ave* St.; *10* yrs., *10* mos. *7* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *F* 4-COLOR OR RACE *W* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, *5* *8*, *1921*  
(Month) (Day) (Year)

7-AGE, *10* yrs., *7* mos., *7* da. If LESS than 1 day, ....hrs. or ....min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work *none*  
(b) General nature of industry, business, or establishment in which employed (or employer) *job*

9-BIRTHPLACE, (State or Country), *Ind*

10-NAME OF FATHER, *John J. Hinks*

11-BIRTHPLACE OF FATHER (State or Country), *Ind*

12-MAIDEN NAME OF MOTHER *Jessie A. M. Davis*

13-BIRTHPLACE OF MOTHER (State or Country), *Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mr. John J. Hinks*

(Address) *Belvidere Ave*

15- *ROBERT R. KRAUTER,*

Filed *MAR 17 1922* *Burial Permit*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *March* *14*, *1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Feb 28* 1922, to *March 14* 1922, that I saw her alive on *March 14* 1922, and that death occurred, on the date stated above, at *1040* a.m. The CAUSE OF DEATH\* was as follows:  
*Bronchitis Pneumonia*

(Duration).....yrs.....mos.....da.

CONTRIBUTORY *cardiac insufficiency*  
(Secondary)

(Duration).....yrs.....mos.....da.

(Signed) *Thos. B. Halden* M. D.

*2-15-1922* (Address) *Halden*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs.....mos.....da. In the State .....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

*St. Charles Place* *March 17, 1922*

20-UNDERTAKER ADDRESS

*John H. Gough* *1001 S. E. 1st St.*

*John H. Gough*

## Remarks

*No infection prior.*

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

*lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

*Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.*

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62461

## CERTIFICATE OF DEATH.

22 D 62461

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 929 S. Paca

ST. 23 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Marie McGiff

(a) RESIDENCE. No. 929 S. Paca

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 7 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 8, 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	7	8	

## 5 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.  
(State or country)

10 NAME OF FATHER John J. McGiff

11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Bertha Bauer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country) Maryland

14 Informant Mrs. J. J. McGiff

(Address) 929 S. Paca St.

15 Filed MAR 17 1922 ROBERT H. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15, 1922

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1922, to March 15, 1922, that I last saw her alive on March 15, 1922, and that death occurred, on the date stated above, at 6.30 P. M. The CAUSE OF DEATH\* was as follows:

Anterior Poliomyelitis with subsequent bed confinement.

(duration) 2 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. K. Skilling M. D.

3-16, 1922 (Address) 4107 Liberty Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Peter's Cemetery Mar. 18 1922

20 UNDERTAKER ADDRESS

John J. McGiff  
St. Peter's Cemetery

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62462

## CERTIFICATE OF DEATH.

D 62462

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *630 Ave*

ST.;

WARD) *9*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mary M. Bellman*(Residence in Baltimore: No. *630 Ave*St.; *—* yrs. *6* mos. *—* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *F.*4-COLOR OR RACE, *W.*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

## 6-DATE OF BIRTH,

*Apr. 12, 1921*  
(Month) (Day) (Year)

## 7-AGE,

*1* yrs. *1* mos. *—* ds.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *none*(b) General nature of industry, business, or establishment in which employed (or employer). *OOD*9-BIRTHPLACE, (State or Country), *Penna.*10-NAME OF FATHER, *Alex. Kinsley*11-BIRTHPLACE OF FATHER (State or Country), *Not known*12-MAIDEN NAME OF MOTHER *Ella Bellman*13-BIRTHPLACE OF MOTHER (State or Country), *Ind.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs Ella Bellman*(Address) *630 Ave St.*

MARI 7 1922

ROBERT N. KRAUTER,

Filed..... 191... *Permit Clerk* Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*March 15, 1922*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*March 14, 1922, to March 15, 1922*that I saw him alive on *March 15, 1922*and that death occurred, on the date stated above, at *8 P. m.*

The CAUSE OF DEATH\* was as follows:

*Measles*(Duration)..... yrs. .... mos. .... ds. *3*CONTRIBUTORY (Secondary) *Branch Pneumonia*(Duration)..... yrs. .... mos. .... ds. *2*(Signed) *Keptinckle Jr.* M. D.*March 14, 1922* (Address) *630 Ave St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

*Penna.*

## 19-PLACE OF BURIAL OR REMOVAL,

*Baltimore Cemetery*

## DATE OF BURIAL,

*March 17, 1922*

## 20-UNDERTAKER

*George J. Ruth* ADDRESS *1735 Hayford Ave.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62463

## CERTIFICATE OF DEATH.

162 ✓ D 62463

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 13 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Julie Marcel

## (a) RESIDENCE NO.

2278 Woodberry Ave.

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Feb 8th 1922

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

18

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

## 10 NAME OF FATHER

Benelist Marcel

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Rumania

## 12 MAIDEN NAME OF MOTHER

Clara Cohn

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Rumania

## 14

Informant (Address)

JOHNS HOPKINS HOSPITALRecords

## 15

MAR 17 1922ROBERT R. KRAUTER,Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16th 1922

## 17

I HEREBY CERTIFY, That I attended deceased from March 15th 1922 to March 16th 1922, that I last saw her alive on March 16th 1922, and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH\* was as follows:

Infection of Umbilicus

(duration)

yrs.

mos.

ds.

## CONTRIBUTORY (Secondary)

Streptococcus meningitis

(duration)

yrs.

mos.

ds.

## 18 Where was disease contracted if not at place of death?

homeDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? lumbar puncture(Signed) Horace G. Stewart, M. D.3/17, 1922 (Address) Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

MOVA  
Health Reform Clin3/17 1922

## 20 UNDERTAKER

## ADDRESS

Jack Lewis 1427 3/2 Balt

D 62464

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62464

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 315 N Bruce ST.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 315 N. Bruce St St.; ..... yrs. .... mos. .... ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

F

## 4-COLOR OR RACE

Colored

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

## 6-DATE OF BIRTH,

March 5, 1922  
(Month) (Day) (Year)

## 7-AGE,

..... yrs. .... mos. .... ds.

If LESS than 1 day,

..... hrs. or ..... min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,  
(State or Country),

Md.

## 10-NAME OF FATHER,

Howard &amp; Neel Smith

## 11-BIRTHPLACE OF FATHER

(State or Country),

Va.

## 12-MAIDEN NAME OF MOTHER

Lennie Rogers

## 13-BIRTHPLACE OF MOTHER

(State or Country),

Md.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jamie Smith  
(Address) 315 N. Bruce St

## 15-

MAR 17 1922 ROBERT R. KRAUTER,  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

March 16, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

3/14 1922, to 3/16 1922,that I saw him alive on 3/16 1922,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH\* was as follows:

Acute Gastro-enteritis  
(Duration) ..... yrs. .... mos. .... ds.CONTRIBUTORY  
(Secondary)

(Duration) ..... yrs. .... mos. .... ds.

(Signed)

J M Hays M. D.  
3/16, 1922 (Address) 518 N. Calver St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Samuel CemeteryMarch 17, 1922

## 20-UNDERTAKER

## ADDRESS

Elmer B. Pyle 1022 Mulberry St



D 62465

Solon H Stewart  
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62465

## CERTIFICATE OF DEATH

1-PLACE OF DEATH *University Hospital*  
CITY OF BALTIMORE: (No. *Farmers Green St.* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
2-FULL NAME *Solon H. Stewart*  
(a) RESIDENCE. No. *Glenburnie Road* WARD.  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *married*  
5a If married, widowed, or divorced HUSBAND of *WIFE*?  
6 DATE OF BIRTH (month, day, and year) ?  
7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*72 years*  
8 OCCUPATION OF DECEASED  
(a) Trade, profession or particular kind of work *Farmer*  
(b) General nature of industry, business, or establishment in which employed (or employer) *086*  
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Maryland*10 NAME OF FATHER *Joshua Stewart*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Maryland*12 MAIDEN NAME OF MOTHER *Sarah A Stewart*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Maryland*14 Informant *University Hospital* (Address)15 MAR 17 1922 ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-16-22*17 I HEREBY CERTIFY, That I attended deceased from *12-29*, 19*21*, to *3-16*, 19*22*, that I last saw him alive on *3-16*, 19*22*, and that death occurred, on the date stated above, at *11:50 A.M.*  
The CAUSE OF DEATH\* was as follows:  
*Bilateral Broncho-Pneumonia*CONTRIBUTORY (Secondary) *Communicated intertrochanteric fracture right hip.*  
(duration) *2 weeks* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *2-11-22*

Was there an autopsy?

What test confirmed diagnosis? *Clinical findings*(Signed) *R. J. J. J.* M. D.19 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Stewarts Home Cemetery*  
*on Glenburnie Rd*

DATE OF BURIAL

*Mar 18 1922*

20 UNDERTAKER

*John F. Denny*

ADDRESS

*715 Light St*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Walking along & tripped  
over piece wire & fell  
against tree.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62466

## CERTIFICATE OF DEATH.

46 D 62466

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital,ST.: 22 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie Hoore(a) RESIDENCE. NO. 420 S. Charles St.ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
45	--	--	--	--

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Wayne Co.,  
(State or country) North Carolina10 NAME OF FATHER Ruben Ebanson11 BIRTHPLACE OF FATHER (city or town) North Carolina  
(State or country)12 MAIDEN NAME OF MOTHER Becky Wooden13 BIRTHPLACE OF MOTHER (city or town) North Carolina  
(State or country)14 Informant Hospital Records  
(Address) Municipal Hospital.15 Filed MAR 17 1922 ROBERT R. KRAUTER  
Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1922

17

I HEREBY CERTIFY, That I attended deceased from  
December 17, 1921, to March 13, 1922  
that I last saw her alive on March 13, 1922  
and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH\* was as follows:

Inoperable carcinoma of uterusCONTRIBUTORY (Secondary) Cachexia  
(duration) yrs. 10 mos. ds.(duration) yrs. 4 mos. ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date of —Was there an autopsy? yesWhat test confirmed diagnosis? Clinical findings  
(Signed) J. H. Brubaker M. D.3/14/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

W. T. Auburn Mar 17 1922

20 UNDERTAKER

Daniel Eapen Pa. av

D 62467

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 Myrtle Ave. ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Wilson(Residence in Baltimore: No. 502 Myrtle Ave. St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married6-DATE OF BIRTH, (Month) (Day) (Year) 1 1 18677-AGE, 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work. Book (b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country) Baltimore10-NAME OF FATHER But known11-BIRTHPLACE OF FATHER (State or Country) But known12-MAIDEN NAME OF MOTHER But known13-BIRTHPLACE OF MOTHER (State or Country) But known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Wilson(Address) 502 Myrtle Ave.

15-

MAR 17 1922

ROBERT R. KRAUTER,  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH, Mar 16, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Mar 7 1922, to Mar 16 1922, that I saw her alive on Mar 16 1922, and that death occurred, on the date stated above, at 11 m.The CAUSE OF DEATH\* was as follows:  
Gangrene of bowel -  
Voluntarily of bowel  
(Duration) 0 yrs. 0 mos. 8 ds.CONTRIBUTORY (Secondary) La Grippe(Signed) W. B. Ferguson M. D.  
Mar 16, 1922 (Address) 601 Myrtle Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL

New Cathedral Bn March 16, 1922

20-UNDERTAKER ADDRESS

Daniel Easton 916





## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62469

62469

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1344 Woodyear Street  
JOHNS HOPKINS HOSPITAL

ST.:

WARD)

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## 2-FULL NAME

Samuel Brooks

## (a) RESIDENCE. NO.

1344 Woodyear Street

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

15

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Col.

5 Single, Married, Widowed,  
or Divorced (write the word)

Single

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year) Aug. 30, 1921

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

5

15

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

City

## 10 NAME OF FATHER Frederic Brooks

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Va.

## 12 MAIDEN NAME OF MOTHER Eva Dore

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Ma

## 14

Informant  
(Address)

JOHNS HOPKINS HOSPITAL

## 15

MAR 17 1922

ROBERT R. KRAUTER  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) March 15, 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb 2, 1922, to March 4, 1922,

that I last saw him alive on March 4, 1922,

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

None

(Signed)

H. H. Meach

M. D.

, 19

(Address) Harriet Lane Home

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Mr. Andrew Smith

March 17 1922

## 20 UNDERTAKER

## ADDRESS

James H. Lewis

303  
Greenwood St.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62470

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 S. Schroeder ST., 18 WARD)

## 2. FULL NAME

(a) RESIDENCE NO. 110 S. Schroeder ST., 18 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced. (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael King6 DATE OF BIRTH (month, day, and year) Mar. 14-18857 AGE Years Months Days If L.F. than 1 day, hrs. or min. 37

## 8 OCCUPATION DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City10 NAME OF FATHER James Mc Hugh11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland12 MAIDEN NAME OF MOTHER Margaret Brady13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland14 Informant Michael King (Address) 110 S. Schroeder St.15 MART 7 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14<sup>th</sup> 192217 I HEREBY CERTIFY That I attended deceased from March 3<sup>rd</sup> 1922 to March 14<sup>th</sup> 1922. that I last saw her alive on March 14 1922 and that death occurred, on the date stated above, at 11.15 P. M.

The CAUSE OF DEATH\* was as follows:

Lobar pneumoniaCONTRIBUTORY (Secondary) pulmonary edema (duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? Had not been out of house for 10 yrsDid an operation precede death? no Date of ✓Was there an autopsy? noWhat test confirmed diagnosis? usual clinical symptoms (Signed) J. J. P. P. P. M. D.19 (Address) 904 N. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Newbathedalem

20 UNDERTAKER

J. G. Moran

DATE OF BURIAL

3-18-1922ADDRESS forE. B. P. P.



D 62471 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Found floating in water

City of BALTIMORE: (No. .... foot of Hughes St. .... St. .... Ward) 22 182

Registered No. C. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ..... Unknown.

(Residence in Baltimore: No. .... Unknown. .... St.; yrs. .... mos. .... ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-Single, Unknown, Married, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH, Do not know. 1. .... (Month) (Day) (Year)

7-AGE, about 45 yrs. .... mos. .... ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Do not know. (b) General nature of industry, business, or establishment in which employed (or employer) 087

9-BIRTHPLACE, (State or Country), Do not know.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER, (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Report.

(Address) .....

15- MARI 7 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

Filed .... 192 .....

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, found floating March 7, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to death (Inquest, autopsy or Inquiry.) on the day stated above. The CAUSE OF DEATH\* was as follows:

Drowning. Probably accidental.

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) .....

(Duration) .... yrs. .... mos. .... ds.

(Signed) E. S. Reinhardt M. D. (Coroner.)

Mar. 14, 1922 (Address) 1017 S. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY. DATE OF BURIAL, MAR 17 1922

20-UNDERTAKER, ADDRESS

Morgue

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62472

## CERTIFICATE OF DEATH.

D 62472

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 E. Fort Ave. ST. 24 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

## (a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

85 yrs. mos. ds.

## ST. WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 14, 1837

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Blacksmith (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

B &amp; O Ry Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant (Address)

Amie King 319 E. Fort Ave.

15

MAR 17 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3. 14 19 22

17

I HEREBY CERTIFY, That I attended deceased from

19 14, to 3. 14, 19 22

that I last saw him alive on 3. 14, 22, 19

and that death occurred, on the date stated above, at 7. 20 P. m.

The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Clinical Only

(Signed) Philip B. Fowler M. D.

B. 15, 1922 (Address) 1432 William St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

C. J. Lorraine Cemetery

3/17 1922

## 20 UNDERTAKER

## ADDRESS

C. J. Lorraine 1460 Rutledge Ave

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No hemorrhage*

10.62473

## HEALTH DEPARTMENT—CITY OF BALTIMORE

10.62473

## CERTIFICATE OF DEATH.

REGISTERED No. C

## PLACE OF DEATH

CITY OF BALTIMORE (No. 10)

WARD

## FULL NAME

(Residence in Baltimore: No.

St.; yrs., 7 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

## 4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

## 6-DATE OF BIRTH,

## 7-AGE,

If LESS than 1 day,

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE.  
(State or Country),

## 10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

## 12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

Filed

191

1922

Robert P. Harrison,

Burial Permit Clerk.

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

## 17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereon and from the evidence obtained by said

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)

(Signed)

3-17-1912 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs.... mos.... ds. In the State.... yrs.... mos.... ds.

Where was disease contracted, if not at place of death?.....

## Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

## 20-UNDERTAKER

## ADDRESS



D 62474

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62474

## CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 913 n Caroline St. 7 WARD)

2-FULL NAME

Eva Miller

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 913 n Caroline St. 34 yrs., 34 mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

W

5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

Married

6-DATE OF BIRTH,

(Month) (Day) (Year)

7-AGE,

34 yrs. 34 mos. ds.

If LESS than 1 day,  
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)037  
House Work9-BIRTHPLACE,  
(State or Country),

Maryland

PARENTS.

10-NAME OF FATHER,

Wesley Ranson

11-BIRTHPLACE OF FATHER  
(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Julia Johnson

13-BIRTHPLACE OF MOTHER  
(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Miller

(Address) 913 n Caroline St.

15-MAR 17 1922

ROBERT R. KRAUTER,

Filed 191 Burial Permit: 6122

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Mar 15, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Cerebral Apoplexy  
(Duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. D.

(Coroner)

3-15-1922 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

Laurel

DATE OF BURIAL,

March 18 1922

20-UNDERTAKER

John W. Henderson

ADDRESS 1502

Emmourt

D 62475 HEALTH DEPARTMENT—CITY OF BALTIMORE 9<sup>th</sup> D 62475

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3104 McElderry ST.: 7 WARD)

## 2-FULL NAME

Frank Henneke

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE. NO.

3104 McElderry ST.,

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 2 mos. 1 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Jan. 1922

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

OOD

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Ind. Balt.

## 10 NAME OF FATHER

Frank Henneke

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

## 12 MAIDEN NAME OF MOTHER

Elizabeth White

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

## 14

Informant (Address)

Frank Henneke 3104 McElderry

## 15

Filed

MAR 17 1922

J. E. Wahn

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17 1922

17 Dec 28/22

I HEREBY CERTIFY, That I attended deceased from Mar 17 1922

that I last saw him alive on Mar 17 1922

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH\* was as follows:

Acute Cardiac Failure

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

C. W. Meyer &amp; 38 E. Baltimore

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

Holy Redeemer Cemetery March 19 1922

Geo. M. Fink &amp; Son 211 N Wolfe

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62476

## CERTIFICATE OF DEATH.

113 D 62476  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1639 W. Lafayette ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick S. Cole

(a) RESIDENCE NO. 1639 W. Lafayette

(Usual place of abode)

ST., WARD

Length of residence in city or town where death occurred 2 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

MAR 17 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/16/22 19

17

I HEREBY CERTIFY, That I attended deceased from

3/16, 1922, to 3/16/22, 19

that I last saw him alive on 3/16/22, 19

and that death occurred, on the date stated above, at 11:00 P. M.

The CAUSE OF DEATH\* was as follows:

protrusion

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? 1/1

What test confirmed diagnosis? 1/1

(Signed) R. M. H. M. D.

3/17, 1922 (Address) 910 W. 4th St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 62477

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62477

## CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. ....)

FULL NAME

(Residence in Baltimore: No. ....)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1N.)

St.; yrs., mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

(Month) (Day) (Year)

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

F-1922

Robert P. Harrison,

Burial Permit Clerk.

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said..... (Inquest, au-

topsy or inquiry.) and that said deceased came to..... death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Traumatic rupture of arm  
from hammer  
at work  
Duration..... yrs..... mos..... da.

CONTRIBUTORY..... (Secondary)

(Duration)..... yrs..... mos..... da.

(Signed)..... M. D.

M.D. 1917 (Address).....

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place..... In the  
of death..... yrs..... mos..... da. State..... yrs..... mos..... da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS



*Run over by engine*

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*,

*peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

*Abortion*, *Hæmorrhage*, *Meningitis*, *Phlebitis*,  
*Cellulitis*, *Gangrene*, *Miscarriage*, *Pyæmia*,  
*Childbirth*, *Gastritis*, *Necrosis*, *Septicæmia*,  
*Convulsions*, *Erysipelas*, *Peritonitis*, *Tetanus*.

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.

154292  
D 62478

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62478

## CERTIFICATE OF DEATH.

31

## 1-PLACE OF DEATH

CITY OF BALTIMORE; (No. JOHNS HOPKINS HOSPITAL)

ST.:

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Jerome Vacek

## (a) RESIDENCE. No.

2210 Ashland Ave City

(Usual place of abode)

(Life) unknown

## WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred: yrs. mos. ds. How long in U.S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 6 If married, widowed, or divorced

Widowed of Jerome Vacek (father)

## 6 DATE OF BIRTH (month, day, and year)

June 23 1894

## 7 AGE

22

Years

Months

9

Days

7

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Id.

## 10 NAME OF FATHER

Jerome Vacek

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Bohemia

## 12 MAIDEN NAME OF MOTHER

Annie Rich

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Bohemia

## 14

Informant (Address)

JOHNS HOPKINS HOSPITAL

## 15

Filed

Robert P. Harrison,

Registrar

7 1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 16 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

March 6 1922 to March 16 1922that I last saw him alive on March 16 1922and that death occurred, on the date stated above, at 12:50 a.m.

The CAUSE OF DEATH\* was as follows:

Tuberculous meningitis(duration) yrs. 2 1/2 mos. ds.

## CONTRIBUTORY (Secondary)

Encephalitis

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

NoneDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? None(Signed) Francis R. Dieulaide, M. D.Date Mar 16 1922 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Holy RedeemerMarch 20 1922

## 20 UNDERTAKER

Paul Prackman

## ADDRESS

1906 Ashland Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62479

## CERTIFICATE OF DEATH.

D 62479

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 930 N Mulberry ST.; 18 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 930 N Mulberry St.; 70 yrs., 0 mos., 0 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

May

(Month)

(Day)

(Year)

7-AGE,

70

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Baltimore Md.

10-NAME OF FATHER,

John O'Neill

11-BIRTHPLACE OF FATHER

(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Margaret M. Flynn

13-BIRTHPLACE OF MOTHER

(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eliza O'Neill(Address) 930 N. Mulberry St.

15-

Filed

Robert P. Harrison

191

7 1922

Burial Permit Clerk. Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 15, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 10, 1912, to May 15, 1912,that I saw him alive on May 15, 1912,and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH\* was as follows:

Organic Disease of Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Harrison M. D.May 16, 1922 (Address) 930 N. Mulberry St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

DATE OF BURIAL,

3-18-1922

20-UNDERTAKER

H. Branning SonADDRESS 517 N. Schneider St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62480

## CERTIFICATE OF DEATH.

D 62480

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *701 S. Ellwood Ave.* ST., *1* WARD)

## 2. FULL NAME

*John Mattis*(a) RESIDENCE NO. *701 S. Ellwood Ave.* ST., *1* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *40* yrs. mos. ds. How long in U. S., if of foreign birth? *40* yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Agnes Mattis*6 DATE OF BIRTH (month, day, and year) *Jan 26-1893*7 AGE Years *79* Months *1* Days *16* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired Bricklayer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Germany* (State or country)10 NAME OF FATHER *John Mattis*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Margaret Foertsch*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)

14

Informant (Address) *Agnes Mattis*  
*701 S. Ellwood Ave.*

7-1922

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 14 1922*I HEREBY CERTIFY, That I attended deceased from *March 5*, 1922, to *March 14*, 1922, that I last saw him alive on *March 14*, 1922,and that death occurred, on the date stated above, at *11.30 p. m.*

The CAUSE OF DEATH\* was as follows:

*Acute Myocarditis*(duration) yrs. mos. *9* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Geo. J. Schaefer*

M. D.

, 19 (Address) *806 S. 3<sup>rd</sup> St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Sacred Heart Ave.*DATE OF BURIAL *March 18 1922*20 UNDERTAKER *Lilly & Ziller*ADDRESS *4038 N. Ave.*



D 62481

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62481

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. *25* ST. *25* WARD)

## REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *Leeds Ave near Wilkins Ave* St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

## 6-DATE OF BIRTH,

*Sept**10**1875*

(Month)

(Day)

(Year)

## 7-AGE,

*47*

yrs.

mos.

ds.

## If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Carpenter*

## 9-BIRTHPLACE.

(State or Country), *Beth MD*10-NAME OF FATHER, *Nicholas Appel-*

## 11-BIRTHPLACE OF FATHER

(State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Antonia Lorb*

## 13-BIRTHPLACE OF MOTHER

(State or Country), *Germany*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Sapetela Appel*(Address) *Leeds Ave near Wilkins Ave*

## 15-

*Robert P. Harrison,*

191

Burial Permit Clerk. Registrar.

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*March 15**1942*

(Month)

(Day)

(Year)

## 17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Ruptured Liver. Caused by heavy shock in R. side by pickup truck from Circular Drive. He was operating*

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *H. K. Jones* M. D.

(Coroner.)

3-17-1942 (Address) *117 W. Saabys St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

## 19-PLACE OF BURIAL OR REMOVAL,

*Holy Redeemer Church*

## DATE OF BURIAL,

*March 18, 1942*

## 20-UNDERTAKER

*Lilly and Ziller*

## ADDRESS

*403 S. Maple*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62482

D 62482

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

435 S. Ellwood Ave.

ST.:

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

John J. Chandler

## (a) RESIDENCE. NO.

435 S. Ellwood Ave.

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

68

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Unknown 1854

## 7 AGE

68

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Shoekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

## 10 NAME OF FATHER

John Chandler

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

England

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

England

## 14

Informant (Address)

Mrs. Sophia Gaff 435 S. Ellwood Ave.

## 15

Filed

1922

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

3/6 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

3/2 1922, to 3/6 1922.

that I last saw him alive on 3/6 1922.

and that death occurred, on the date stated above, at 3:15 P.m.

The CAUSE OF DEATH\* was as follows:

Asc. Vulp. Oedema. Uremic Convulsions

(duration) yrs. mos. da.

## CONTRIBUTORY (Secondary)

Myocarditis (duration) yrs. mos. da.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Chandler, M. D.

3/6 1922 Address 3325 E. Belvoir

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Sacred Heart Cem.

March 18 1922

## 20 UNDERTAKER

Lilly and Ziehl

## ADDRESS

403 S. 8th St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62483

D 62483

## CERTIFICATE OF DEATH.

31

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 35 Ellwood ST.; 1 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Elizabeth C. Polger

(a) RESIDENCE. No. 35 Ellwood ST.; 1 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 4 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Polger

6 DATE OF BIRTH (month, day, and year) Nov. 15, 1890

7 AGE Years 31 Months 4 Days 1 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md. (State or country)

10 NAME OF FATHER Chas. Young

11 BIRTHPLACE OF FATHER (city or town) Balto Md. (State or country)

12 MAIDEN NAME OF MOTHER Sarah Squire

13 BIRTHPLACE OF MOTHER (city or town) Balto Md. (State or country)

14 Informant Louis Polger (Address) 35 Ellwood Ave

15 Filed Robt. P. Harrison, Registrar

1922

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16, 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1922, to March 16, 1922, that I last saw her alive on March 15, 1922, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH\* was as follows:

Phthisis Pulmonalis

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? E

(Signed) inf m. away M. D.

19 (Address) 839 J. Ellwood Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Bonnie Brae Mar 20 1922

20 UNDERTAKER ADDRESS

Edmund W. Conklin 944 E. E. Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 62484

## CERTIFICATE OF DEATH. X 84

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Low Robert Gillespie Blaine

## (a) RESIDENCE NO.

133 C. S.E. Washington ST., D.C.

## WARD

Wash. D.C.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

April 23 1877

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

D.C.

## 10 NAME OF FATHER

Robert Gillespie Blaine

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa.

## 12 MAIDEN NAME OF MOTHER

Rebecca A. Hirsch

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

D.C.

## 14

Informant (Address)

JOHNS HOPKINS HOSPITAL Records.

## 15

Filed

Robert P. Ball

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 17 1922

## 17

I HEREBY CERTIFY, That I attended deceased from March 13, 1922, to March 17, 1922, that I last saw him alive on March 17, 1922, and that death occurred, on the date stated above, at 2 11 a.m.

## The CAUSE OF DEATH\* was as follows:

Shock following operation(duration) yrs. mos. 1 1/2 ds.

## CONTRIBUTORY (Secondary)

Brain tumor(duration) 5 yrs. 4 mos. ds.

## 18 Where was disease contracted if not at place of death?

Wash. D.C.Did an operation precede death? Yes Date of 3-15-22Was there an autopsy? NoWhat test confirmed diagnosis? Tumor exposed at operation(Signed) Warfield M. Fier, M. D.3/17/1922 (Address) J. W. Hays, Balto

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Washington D.C.

## DATE OF BURIAL

3/17 1922

## 20 UNDERTAKER

Chas. P. Evans & Son 1180 N. Royal Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62485

## CERTIFICATE OF DEATH.

90. D 62485

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 Towson ST. 24 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta J. Roether(a) RESIDENCE. NO. 1108 Towson ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 150 yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Roether6 DATE OF BIRTH (month, day, and year) June 15 - 18537 AGE 68 Years 9 Months 11 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home(b) General nature of industry, business, or establishment in which employed (or employer) for

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Amelia Brookes13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany14 Informant Emil A. Roether (Address) 2238 Madison Ave15 71922 Robert P. Harrison, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 192217 I HEREBY CERTIFY, That I attended deceased from Oct. 16, 19 21, to March 16, 19 22that I last saw her alive on March 15, 19 22and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH\* was as follows:

Acute Dilatation of Heart(duration) 3 hrs yrs. — mos. — ds.CONTRIBUTORY (Secondary) Myocarditis(duration) 6 mos. yrs. — ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? None(Signed) Thos F. Stevens, M. D.(Address) 2578 Hartford Rd.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Wm. Olivet Cw.3/18 1922

20 UNDERTAKER

ADDRESS

Chas. P. Evans & Son 1810 Mt. Royal Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62486

D 62486

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2200 Harford Ave ST. 9 WARD)

## 2. FULL NAME

Felix T. Riley

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 2200 Harford Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Lifetime

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 4-1871

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

50

8

11

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Grain Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

Peter Riley

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Margaret Murphy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant (Address)

Mollie Riley  
2200 Harford Ave  
Robert T. Riley

15

7 1922

Burial Permit Clerk, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 15 1922

17

I HEREBY CERTIFY, That I attended deceased from

Mar 4 1922 to Mar 15 1922

that I last saw him alive on Mar 15 1922

and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH\* was as follows:

Broncho pneumonia  
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

F. T. Riley M. D.  
110 E. South Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

Cathedral Cemetery

DATE OF BURIAL

3/18 1922

ADDRESS

Chas. H. Wane &amp; Son 118 W. Mt. Royal Ave

15-446 62487 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

161 62487  
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Sylvia McCullom

(a) RESIDENCE. No.

616 N. Pearl ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb. 27/1922

7 AGE

Years

Months

Days

If LESS than  
1 day, \_\_\_\_ hrs.  
or \_\_\_\_ min.14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore Md.

10 NAME OF FATHER

Herbert McCullom

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

N. Carolina

12 MAIDEN NAME OF MOTHER

Bessie Stenson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

N. Carolina

14

Informant

(Address)

JOHNS HOPKINS HOSPITAL

15

Filed

Robt. E. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 13<sup>th</sup> 1922 to March 13<sup>th</sup> 1922that I last saw him alive on March 13<sup>th</sup> 1922and that death occurred, on the date stated above, at 6:35 P.M.

The CAUSE OF DEATH\* was as follows:

Prematurity

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

CONTRIBUTORY  
(Secondary)

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? \_\_\_\_ Date of \_\_\_\_

Was there an autopsy? \_\_\_\_

What test confirmed diagnosis? Weight 1 1/2 lbs.(Signed) T. B. Gay, M. D., 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF REMOVAL

JOHNS HOPKINS HOSPITALMAR 17 1922

20 UNDERTAKER

ADDRESS

Commissioner Health,Wm E. Woodall

15-3B 62488

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST. 12 WARD)

## 2-FULL NAME

Mary Brown

## (a) RESIDENCE. No.

419 E. 23<sup>rd</sup>

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

suburban

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

June 7<sup>th</sup> 1921

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.97

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Lab

(b) General nature of industry, business, or establishment in which employed (or employer)

100

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

?

## 10 NAME OF FATHER

George Greene

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md.

## 12 MAIDEN NAME OF MOTHER

Mary Brown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

## 14

Informant (Address)

JOHNS HOPKINS HOSPITAL

## 15

Filed

7 1922

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 14 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan. 19<sup>th</sup> 1922, to March 14, 1922that I last saw her alive on March 14<sup>th</sup> 1922and that death occurred, on the date stated above, at 6 40 A.M.

The CAUSE OF DEATH\* was as follows:

Rickets

(duration)

yrs.

mos.

ds.

## CONTRIBUTORY (Secondary)

Bronchopneumonia

(duration)

yrs.

mos.

ds.

18 Where was disease contracted? Rickets at home  
If not at place of death? Bronchopneumonia in hospitalDid an operation precede death? No Date ofWas there an autopsy? yesWhat test confirmed diagnosis? X-Ray

(Signed)

Horace G. Stewart

M. D.

3/15, 1922

(Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF

JOHNS HOPKINS HOSPITALMAR 17 1922

## 20 UNDERTAKER

ADDRESS

Commissioner Health,



62489

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62489

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 13 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. 2628 Town ST. over WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 18

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Wm. Ennis11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.12 MAIDEN NAME OF MOTHER Ada Bond13 BIRTHPLACE OF MOTHER (city or town) (State or country) M.C.14 Informant JOHNS HOPKINS HOSPITAL (Address)7-1922 Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

March 13, 1922, to March 13, 1922,that I last saw him alive on March 13, 1922,and that death occurred, on the date stated above, at 11:40 P. m.

The CAUSE OF DEATH\* was as follows:

Unable to diagnose  
Choked discs - Coma - convulsions.  
Spinal fluid - 18 cells - positive  
globulin. No fever  
(duration) yrs. mos. 31 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? yes. Not completed yet.

What test confirmed diagnosis?

(Signed) Horace G. Stewart, M. D.3/15, 1922 (Address) Johns Hopkins Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

Commissioner of Health,Per. Wm. H. Woodall.

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Brain abscess cause unknown.*

*Kramer's Drug Store gave information as address being Florence St. Referred to above by Dr. J. H. Hopt.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62490

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No

616 Sterling St.

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Lucinda Blake

## (a) RESIDENCE. No

616 Sterling St.

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female Colored Undown

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Geo Blake

6 DATE OF BIRTH (month, day, and year)

Oct. 1859

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

62

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

md

(State or country)

10 NAME OF FATHER

William Snouder

11 BIRTHPLACE OF FATHER (city or town)

md.

(State or country)

12 MAIDEN NAME OF MOTHER

Lucy Brown

13 BIRTHPLACE OF MOTHER (city or town)

md

(State or country)

14

Informant

(Address)

George Blake  
616 Sterling St.

15

Filed

Robert P. Harrison,

Registrar

7 1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 18 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 18, 1922, to March 17, 1922,

that I last saw him alive on March 16, 1922,

and that death occurred, on the date stated above, at 10<sup>00</sup> a.m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis  
and Broken Compensation  
of heart.

(duration) 1/2 yrs. 6 mos. 1 ds.

CONTRIBUTORY

(Secondary)

old age &amp; arteriosclerosis (duration) 1 yrs. 4 mos. 4 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Physical examination

(Signed)

G. S. Hall, M. D.

, 19

(Address) 426 E 23 St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn March 22 1922

20 UNDERTAKER

ADDRESS

Charles W. Wright 136 E. 23 St.

D 62491

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62491

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1106 N. Charles

ST.

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Anne Graham Bowdoin

## (a) RESIDENCE.

No. 1106 N. Charles

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed,

or Divorced (write the word)

Single

## 5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Child

## 6 DATE OF BIRTH (month, day, and year)

Dec 7, 1920

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

1

3

9

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

Baltimore

(State or country)

Maryland

## 10 NAME OF FATHER

W. G. Bowdoin

## 11 BIRTHPLACE OF FATHER (city or town)

Baltimore

(State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

E. Laura McLean

## 13 BIRTHPLACE OF MOTHER (city or town)

Baltimore

(State or country)

Maryland

## 14

Informant

Mr. Graham Bowdoin

(Address)

1106 N. Charles St.

## 15

Date

7/19/22

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 16, 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

March 3, 1922, to March 16, 1922.

that I last saw him alive on March 16, 1922.

and that death occurred, on the date stated above, at 10:15 A. M.

The CAUSE OF DEATH\* was as follows:

Pyelitis

(duration) — yrs. — mos. 14 ds.

## CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. 1 ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis P. Humberger, M. D.

Address 1207 E. Euter St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Greenmount Cemetery March 18, 1922

## 20 UNDERTAKER

## ADDRESS

Henry Jenkins &amp; Son Co. 1106 N. Charles St.



Supplies. AGE should be stated EXACTLY. PHYSICIANS should in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 62492

PLACE OF DEATH

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No.

1462 Reynolds

WARD)

FULL NAME

Apolonia Susnowicz

(Residence in Baltimore: No.

1462 Reynolds

St.: 16 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

Aug 15, 1857

7 AGE

64 yrs. 7 mos. 1 ds.

IF LESS than

1 day, hrs.

or min.?

8 OCCUPATION

(a) Trade, profession, or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

Housewife

9 BIRTHPLACE

(State or country)

Poland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER

(State or country)

Poland

12 MAIDEN NAME OF MOTHER

Anna Gedrich

13 BIRTHPLACE OF MOTHER

(State or country)

Poland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Francis Susnowski

(Address)

1462 Reynolds

15

Robert P. Harrison,

191

Burial Permit Clerk,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Mar 16, 1922

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

March 15, 1922, to, March 16, 1922,

that I saw her alive on March 16, 1922,

and that death occurred, on the date stated above, at, 2:15 p.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

Contributory

(SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

Thos F. Stevens

M. D.

3/17/22 (Address) 2878 Hartford

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

Yrs. mos. ds.

In the

State

Yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Cross Church

March 18, 1922

20 UNDERTAKER

ADDRESS

John W. Eter

1803 Bank



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62494

D 62494

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 770 St Peter ST., 21 WARD)

## 2. FULL NAME

Maggie G. Biddle

## (a) RESIDENCE NO.

770 St Peter

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Mar-5-1868

## 7 AGE

Years

Months

Days

If LESS than 1 day, .... hrs. or .... min.

53

4

12

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

None

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

City

## 10 NAME OF FATHER

W. H. Biddle

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

City

## 12 MAIDEN NAME OF MOTHER

Rebecca Williams

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

City

## 14

Informant (Address)

E. W. Nelson 3113 3rd St

## 15

Filed

Robert P. Harrison,

Registrar

1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) Mar. 17 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb 15, 1922, to March 17, 1922.

that I last saw him alive on March 16, 1922,

and that death occurred, on the date stated above, at 2 A. M.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Disease of Heart

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death?

Yes

Date of Feb 15, 1922

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assoc.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Operation for phlebitis.*  
*Cause of which*  
*was unknown.*



D 62495

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62495

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1923 E. Lombard* ST.; *2* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*Barbara Leitch*(Residence in Baltimore: No. *1923 E. Lombard* St.; ..... yrs., ..... mos. .... ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Female*

## 4-COLOR OR RACE,

*White*5-SINGLE, *Married*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

*June 24, 1897*  
(Month) (Day) (Year)

## 7-AGE,

*74 yrs. 8 mos. 16 ds.*If LESS than 1 day,  
.... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular  
kind of work.....  
(b) General nature of industry, busi-  
ness, or establishment in which  
employed (or employer).....*None*9-BIRTHPLACE,  
(State or Country),*Baltimore Md*10-NAME OF  
FATHER,*Joseph Pscherrer*11-BIRTHPLACE  
OF FATHER  
(State or Country),*Germany*12-MAIDEN NAME  
OF MOTHER*Margaret Schauburger*13-BIRTHPLACE  
OF MOTHER  
(State or Country),*Germany*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

*John G. Leitch*

(Address).....

*1923 E. Lombard St*

## 15-

Robert P. Harrison,

Aug 18 1922

Registrar.

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*March 16, 1922*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from  
*Dec. 1, 1921*, to *March 16, 1922*,  
that I saw her alive on *March 16, 1922*,  
and that death occurred, on the date stated above, at *5* m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Breast*

(Duration)..... yrs. .... mos. .... ds.

CONTRIBUTORY... *Myocarditis*  
(Secondary)

(Duration)..... yrs. .... mos. .... ds.

(Signed) *Eugene L. Casagno* M. D.*March 17, 1922* (Address) *Ten Hills*\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,  
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted,  
if not at place of death?.....

Former or usual residence.....

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Baltimore**March 23, 1922*

## 20-UNDERTAKER

## ADDRESS

*Martin W. C. [Signature]*

D 62496 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62496

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *1433 Eastern Ave* St. *90* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *1433 Eastern* St., yrs., mos., ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *M* 4-COLOR OR RACE, *W* 5-Single, Married, Widowed, *Widowed* or Divorced, (Write the word.)6-DATE OF BIRTH, *August* *30*, 18*97* (Month) (Day) (Year)7-AGE, *74* yrs., *6* mos., *13* ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *Labor*  
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *Balt*PARENTS.  
10-NAME OF FATHER, *John Dash*  
11-BIRTHPLACE OF FATHER, (State or Country), *Germany*  
12-MAIDEN NAME OF MOTHER, *Don't know*  
13-BIRTHPLACE OF MOTHER, (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Rose Hoag*(Address) *1433 Eastern ave*15- *Robert F. Harrison*  
Filed 19*22* Registrar.

81922 Burial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *Mar. 15* *22* (Month) (Day) (Year)17- I HEREBY CERTIFY that I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)*inquest* and from the evidence obtained by said *inquest*, find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH was as follows:

*Myocard Steuosis*CONTRIBUTORY (Secondary) *Broken (ruptured) aorta*(Signed) *G. B. Bladen* M. D. (Address) *1433 Eastern Ave*

\*State the Disease Causing Death, or, in deaths from violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).  
At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Carmel* DATE OF BURIAL, *March 18, 1922*20-UNDERTAKER, *Wendell Duffel* ADDRESS *37 S. Mm*

D 62497

## HEALTH DEPARTMENT—CITY OF BALTIMORE

170D 62497

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Joseph Hospital*)

REGISTERED NO. C

2-FULL NAME

*Raniero Puschi*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *403 S. Eden*)at *(19)*  
St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE

*White*5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)  
*Married*

6-DATE OF BIRTH,

*May 15 1918*  
(Month) (Day) (Year)

7-AGE,

*38 yrs. 10 mos. ds.*

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*Labor 040*

9-BIRTHPLACE.

(State or Country),

*Italy*

10-NAME OF FATHER,

*Salvatore Puschi*

11-BIRTHPLACE OF FATHER (State or Country),

*Italy*

12-MAIDEN NAME OF MOTHER

*Elvira Culpertio*

13-BIRTHPLACE OF MOTHER (State or Country),

*Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. T. Puschi*(Address) *403 S. Eden*

15-

*Robert P. Harrison*

191

Registrar.

*Burial Permit Clerk*

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Mar 15 1919*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquest*  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Inquest*  
(Inquest, autopsy or inquiry.)

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Suicide by pistol shot*

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*Wm. J. Puschi*  
(Coroner.)*3-15, 1919* (Address) *403 S. Eden*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Mary's Cemetery* *March 17 1919*

20-UNDERTAKER

ADDRESS

*Martin McArthur*

Important. See instructions on back of certificate.

D 62498

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62498

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1721 Barclay St. 17 WARD)

2-FULL NAME

Elie Thelma Cornwell

(Residence in Baltimore: No. 1721 Barclay

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

white

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

Single

6-DATE OF BIRTH,

, 1 (Month) (Day) (Year)

7-AGE

5 yrs. 5 mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

not

9-BIRTHPLACE,  
(State or Country),

Baltimore

10-NAME OF FATHER,

R. Cornwell

11-BIRTHPLACE OF FATHER  
(State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Carrie Cornwell

13-BIRTHPLACE OF MOTHER  
(State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Carrie Cornwell

(Address)

1721 Barclay St.

15-

8 1922

Robert E. Harrison,

Registrar.

Burial Permit clerk.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

April 15, 1922

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Dementia 10 days

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. T. Riley

(Coroner.)

M. D.

1039 Bay

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Mary's Hampden

3/18, 1922

20-UNDERTAKER

ADDRESS

George F. Ruth

1735 Harford



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62499

## CERTIFICATE OF DEATH.

D 62499

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 W LOUMBARD

ST.:

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME ANTANAS KALINAVCKAS

(a) RESIDENCE. No. 712 W LOUMBARD

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? 11 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nokow

7 AGE 37

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

TAILOR

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

Nokow

9 BIRTHPLACE (city or town)  
(State or country)

LITHVANIA

10 NAME OF FATHER

Adom Kalinavckas

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

LITHVANIA

12 MAIDEN NAME OF MOTHER EVA KICHAS

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

LITHVANIA

14

Informant

(Address)

ADOM KALINAVCKAS

712 W LOUMBARD STREET

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16th 22

17

I HEREBY CERTIFY, That I attended deceased from

March 12, 1922, to March 15, 1922,

that I last saw him alive on March 15, 1922,

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed)

E. B. Brownshas

M. D.

3-17-1922 Address 615 Columbia Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

HOLY REDEEMER

March 20 1922

20 UNDERTAKER

ADDRESS

JOHN GREBLIAUCKAS

425 S PACA

St

This certificate should be filed in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

State of Maryland, Department of Health, City of Baltimore. This certificate is to be filled out by the physician or other person in charge of the institution where the death occurred. It is to be filed in the office of the Registrar of the City of Baltimore. The information furnished on this certificate is for the purpose of compiling statistics and is not to be used for any other purpose. The information furnished on this certificate is to be kept confidential and is not to be disclosed to any person except as may be required by law. The information furnished on this certificate is to be kept confidential and is not to be disclosed to any person except as may be required by law.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62500

## CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1117 Riggs Ave ST. 16 WARD)

2-FULL NAME

John T. Holland

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1117 Riggs Ave.

St.: yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male 4-COLOR OR RACE, colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, married (Write the word.)

6-DATE OF BIRTH, Dec. 24, 1884 (Month) (Day) (Year)

7-AGE, 38 yrs., 2 mos., 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, cook (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md.

10-NAME OF FATHER, Wm. Holland

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Anna Burton

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. T. Holland

(Address) 1117 Riggs Ave.

15- Robert P. Hart 1892, Registrar.

8 1922

191. Burial Permit Clerk.

Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 14, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Holland M. D. (Coroner.)

March 17, 1922 (Address) 2802 E. Baltimore St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Cooksville, Howard Co. Md. 3-18-22

20-UNDERTAKER, ADDRESS

John H. Treadwell 142 W. 1st St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62501

## CERTIFICATE OF DEATH.

D 62501

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1M.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

8 1922

Robert P. Harrison,

101

Registrar.

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. 4 mos. 7 da. In the State 51 yrs. 10 mos. 18 da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62502

D 62502

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Little Sister of the Poor*, ST.: *10* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Elizabeth Young*(a) RESIDENCE. NO. *Frederick Valley*

ST. WARD.

Length of residence in city or town where death occurred *1* yrs. *1* mos.How long in U. S., if of foreign birth? *1* yrs. *1* mos. *1* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*Colored*

5 Single, Married, Widowed, or Divorced (write the word)

*Widow*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Deris Young*6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE

*about 65*

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

*off*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore*10 NAME OF FATHER *Henry Wilson*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)12 MAIDEN NAME OF MOTHER *Charlotte Brown*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant *Sister Florence*  
(Address) *Frederick Valley*

15

*81922 Robert F. Hart 1922*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 17 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*10 second*that I last saw him alive on *March 12 1922*and that death occurred, on the date stated above, at *8 a.* m.

The CAUSE OF DEATH\* was as follows:

*Valvular Disease of heart**Unknown*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)(duration) *9* yrs. mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

*Wien*  
(Signed)*W. H. Warner, M. D.*

19 (Address)

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Cathedral Cem.*

DATE OF BURIAL

*Mar 18 1922*

20 UNDERTAKER

*N. E. Wiedefeld*

ADDRESS

*94  
Greenmount  
Ave.*Exact statement of OCCUPA-  
tion, if property classified. See instructions on back of certificates.



D 62503

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62503

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 27 WARD)

2-FULL NAME

Earl Way

(a) RESIDENCE. NO.

101 George Ave Hamilton Rd.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Yrs.

mos.

ds.

Now long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

Dec 6 1914

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7

3

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Geo Way (deceased)

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Ellen Preston

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Ellen Way

101 George Ave Hamilton Rd.

1922

19

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 15 1922 to March 17 1922

that I last saw him alive on March 17, 1922.

and that death occurred, on the date stated above, at 10:00 A. M.

The CAUSE OF DEATH\* was as follows:

Acute suppurative  
Appendicitis. Diffuse peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocardial insufficiency  
6 hrs. Edema lungs

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of March 15, 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Cyrus J. Harine, M. D.

19 (Address) University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western View

March 20 1922

20 UNDERTAKER

ADDRESS

Chenoweth &amp; Son Chestnut St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62504

D 62504

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO) Municipal Tuberculosis Hospital 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Young

(a) RESIDENCE. No. 2143 Woodberry st.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Fred Young

6 DATE OF BIRTH (month, day, and year) Unknown 1886

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 36 Unknown

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER Wm. Imhoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Susie Hudson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) M. T. H.

8-19-22 Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16, 1922

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1922, to March 16, 1922, that I last saw him alive on March 16, 1922, and that death occurred, on the date stated above, 3.20 p. m. The CAUSE OF DEATH\* was as follows:

pulmonary tuberculosis

(duration) 1 yrs 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis DeBoghe M. D.

3-16-22 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St Marys Hospital March 20, 1922

20 UNDERTAKER ADDRESS

Chenoweth &amp; Son Chestnut

D 62505 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 548 W, Lee ST. 22 WARD)

## 2-FULL NAME

Sarah Ann Green

## (a) RESIDENCE. NO.

548 W, Lee

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced (write the word)

Widowed

## 5a If married, widowed, or divorced

(or) WIFE of

John Green

## 6 DATE OF BIRTH (month, day, and year)

1842

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

80

-

-

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Formerly

(b) General nature of industry, business, or establishment in which employed (or employer)

a Coop.

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Annie Arundel Co. Maryland

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

Elizabeth

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

## 14

Informant

Richard Green

(Address)

548 W - Lee St

## 15

Filed

19

Robert P. Harrison,

Registrar

MAR 18 1922

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar, 16 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct, 12 1922, to Mar, 16 1922.

that I last saw him alive on Mar, 15 1922.

and that death occurred, on the date stated above, at 4:40 a. m.

The CAUSE OF DEATH\* was as follows:

Chronic myocarditis

(duration)

Unknown

## CONTRIBUTORY

(Secondary)

Arterio sclerosis, Chr -

Inter nephritis

(duration)

Unknown

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

Urine, 4 pr, course.

(Signed)

Dan J. Franklin, M. D.

3/16 1922 Address)

22 W - Lee St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL CREMATION OR REMOVAL

## DATE OF BURIAL

St Peter's Church March 19 1922

## 20 UNDERTAKER

## ADDRESS

David E. E. E.

916

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62506

## CERTIFICATE OF DEATH.

90 D 62506

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1842 MC Henry ST.: 20 WARD)

## 2-FULL NAME

(a) RESIDENCE, No. 1842 MC Henry ST. 20 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. 7 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Blanch C. Thomas

6 DATE OF BIRTH (month, day, and year) July 20-1896

7 AGE Years 25 Months 7 Days 26 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Husketon

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Ind (State or country)

10 NAME OF FATHER Frank W. Thomas

11 BIRTHPLACE OF FATHER (city or town) Balto Ind (State or country)

12 MAIDEN NAME OF MOTHER Blanch C. Whitney

13 BIRTHPLACE OF MOTHER (city or town) Balto Ind (State or country)

14

Informant (Address)

Frank W. Thomas 1842 MC Henry St

15

Filed

Robert P. Harrison

Registrar

8 1922

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1922

17 I HEREBY CERTIFY, That I attended deceased from

during past 2 years 19 to 19 that I last saw him alive on March 15 1922 and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Atherosclerosis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Theo Kallenberg M. D.

2017 Dr. Theo Kallenberg

\*State the disease causing death from violent causes, state (1) means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Cemetery Mar. 18 1922

20 UNDERTAKER

ADDRESS

Geo. L. Schwan 2101 E. 11th St. Me.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62507

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE No. 430 N. 23rd St. ST. 12 WARD

## 2. FULL NAME

(a) RESIDENCE NO. 430 N. 23rd St. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Sarah G. Ford

6 DATE OF BIRTH (month, day, and year)

June 11-1834

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

87

9

5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Building Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired 25 years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Co. Md.

10 NAME OF FATHER

David Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Louisa Nogle

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Penn.

14

Informant (Address)

Mrs. Myra B. Shock 430 N. 23rd St.

15

Robert P. Harrison

Registrar

81922

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1922

17

I HEREBY CERTIFY, That I attended deceased from

Dec 10 1922 to March 16 1922

that I last saw him alive on March 16 1922

and that death occurred, on the date stated above, at 1:30 A. M.

The CAUSE OF DEATH\* was as follows:

Dysentery

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 16 Date 16

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. A. Richardson M.D. (Address) 112 W. 25th St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park

DATE OF BURIAL

March 18 1922

UNDERTAKER

Horace H. Burque

ADDRESS

3631 Fall Rd



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62509

## CERTIFICATE OF DEATH.

90 D 62509

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 611 S. Brentn ST. 20 WARD)

## 2-FULL NAME

John J. Morgan

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

611 S. Brentn

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

May Morgan

6 DATE OF BIRTH (month, day, and year)

May 25 - 1856

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

65

9

20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labour

(b) General nature of industry, business, or establishment in which employed (or employer)

040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt-

10 NAME OF FATHER

James E. Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Don't know

14

Informant (Address)

James E. Morgan  
Belair Road, Baltimore

15

Robert P. Harrison

Registrar

8-1922

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 17 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 1 - 1921 to March 17, 1922

that I last saw him alive on March 17, 1922

and that death occurred, on the date stated above, at 3:20 P. M.

The CAUSE OF DEATH was as follows:

Senility, Arterio Sclerosis

CONTRIBUTORY (Secondary)

Died

(duration)

2 yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herbert C. Zitsch, M. D.

3/17, 1922 (Address) 2151 Thelma Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Mary's Graves

DATE OF BURIAL

Mar 21 1922

20 UNDERTAKER

H. C. Cook

ADDRESS

1045 AL

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No hemorrhage.*  
*Chronic endocarditis*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62510

## CERTIFICATE OF DEATH.

101 D 62510

## 1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *807 S. Superior* ST.: *1* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Theodore Williams*(Residence in Baltimore: No. *807 S. Superior* St.: *1* WARD mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Child*6-DATE OF BIRTH, *Oct 15, 1920*

(Month)

(Day)

(Year)

7-AGE, *1 5 1*

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Balto Md*10-NAME OF FATHER, *John Williams*11-BIRTHPLACE OF FATHER (State or Country), *Balto*12-MAIDEN NAME OF MOTHER *Ana Rochowiak*13-BIRTHPLACE OF MOTHER (State or Country), *Balto Md*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Williams*(Address) *807 S. Superior Ave.*

15-

Filed

101

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *March 16, 1912*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *March 14, 1912*, to *March 16, 1912*, that I saw him alive on *16*, 1912, and that death occurred, on the date stated above, at *7:30 P.M.* The CAUSE OF DEATH\* was as follows:

*Empyema of lungs*

(Duration) yrs. mos. ds. *10*

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds. *1*

(Signed) *W. B. Deane*, M. D., *3/17, 1912* (Address) *7600 E. Baltimore St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Anne's Mausoleum*DATE OF BURIAL, *Mar 18, 1912*20-UNDERTAKER, *Stephen J. Fralrowski*ADDRESS, *1000 S. Penwood Ave.*

*Had pleural pneumonia some time ago.  
No infectious disease prior to this.*

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

*lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of.....* (name origin; "Cancer" is less definite; avoid use of "Tumor" for inalignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

<i>Abortion,</i>	<i>Cellulitis,</i>	<i>Childbirth,</i>	<i>Convulsions,</i>
<i>Hæmorrhage,</i>	<i>Gastritis,</i>	<i>Erysipelas,</i>	<i>Meningitis,</i>
<i>Gongrene,</i>	<i>Miscarriage,</i>	<i>Necrosis,</i>	<i>Peritonitis,</i>
<i>Phlebitis,</i>	<i>Pyæmia,</i>	<i>Septicæmia,</i>	<i>Tetanus.</i>

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (if induced), whether death is directly or indirectly due to the same.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62511

## CERTIFICATE OF DEATH.

100-681  
D 62511

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 S. Luzerne ST.; 1 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mieczyslaw Anyszek(a) RESIDENCE. NO. 830 S. Luzerne ST. 1 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 16-19207 AGE Years 1 Months 6 Days 0 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

" "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.10 NAME OF FATHER Andrew Anyszek

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Poland12 MAIDEN NAME OF MOTHER Mary Regula

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Poland14 Informant Andrew Anyszek  
(Address) 830 S. Luzerne15 Filed Robert B. Harrison Registrar

181922

Burial Permit Clerk,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 192217 I HEREBY CERTIFY, That I attended deceased from March 10, 1922, to March 16, 1922.that I last saw him alive on March 16, 1922.and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH\* was as follows:

Bronch. Pneumonia over(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.18 Where was disease contracted if not at place of death? at place of deathDid an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) W. L. Burke, M. D.19 (Address) 3042 Henderson

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Rosary March 18 1922

20 UNDERTAKER ADDRESS

William Laisovsky Car

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62512

## CERTIFICATE OF DEATH.

10 D 62512

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital 75* ST. WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Melba Glade.*

## (a) RESIDENCE. NO.

*Church St. - Curtis Bay* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*male*

## 4 COLOR OR RACE

*white*

## 5 Single, Married, Widowed, or Divorced (write the word)

*single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Sept. 2, 1917*

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*4**6**2*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town, State or country)

*Balto. Md.*

## 10 NAME OF FATHER

*Philip Glade*

## 11 BIRTHPLACE OF FATHER (city or town, State or country)

*Poland*

## 12 MAIDEN NAME OF MOTHER

*Celia Lucas*

## 13 BIRTHPLACE OF MOTHER (city or town, State or country)

*Balto. Md.*

## 14

Informant  
(Address)*Philip Glade  
Curtis Bay*

## 15

Filed

*8 1922**Robert P. Harrison*

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 16 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Oct. 22 1921 to March 16, 1922*that I last saw him alive on *March 16, 1922*and that death occurred, on the date stated above, at *8:00 P.m.*

The CAUSE OF DEATH\* was as follows:

*Diphtheria, tonsillar,  
pharyngeal & laryngeal*  
(duration) — yrs. *4* mos. *29* da.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?*at home*

Did an operation precede death?

*No* Date of

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Cultures (+)*

(Signed)

*Bill Macfarlane M.D.*(Address) *Sydenham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Holy Cross*

## DATE OF BURIAL

*Mar 18 1922*

## 20 UNDERTAKER

*Wm. Halkowski 1418 Eastern Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62513

## CERTIFICATE OF DEATH.

D 62513

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1352

ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Joseph. Kotowski

(a) RESIDENCE. NO.

1352 Reynolds

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Pelagia Kotowski

6 DATE OF BIRTH (month, day, and year)

1872 Not known

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

50

0

0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer. 074

(b) General nature of industry, business, or establishment in which employed (or employer)

None done.

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Poland

10 NAME OF FATHER

Paul. Kotowski

11 BIRTHPLACE OF FATHER (city or town)

Poland

(State or country)

12 MAIDEN NAME OF MOTHER

Mary. Bulgowski

13 BIRTHPLACE OF MOTHER (city or town)

Poland

(State or country)

14

Informant

(Address)

Boleslaw Kotowski

1307 Reynolds

15

Filed

19

Robert P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 17 1922

17

HEREBY CERTIFY, That I attended deceased from

Feb. 1, 1922, to March 17, 1922

that I last saw him alive on March 16, 1922

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. 47 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

No

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

None but urine

(Signed)

J. H. Stevens

M. D.

3/17/22

(Address)

2878 Hatford Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary

Mar 20 1922

20 UNDERTAKER

ADDRESS

William J. Alfonsi

1618 Eastern

81922

Burial Permit Clerk

Exact statement of OCCUPA-  
tion may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62514

D 62514

## CERTIFICATE OF DEATH.

## I-PLACE OF DEATH

CITY OF BALTIMORE: (No. *141* ST. *141* WARD)2-FULL NAME *Mrs. Jane D. Petherbridge*(a) RESIDENCE. NO. *Dunkirk Md.* ST. *Dunkirk Md.* WARD. *Dunkirk Md.*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

15

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,

or Divorced (write the word)

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

8-10-22

Burial Permit Clerk.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

*March 1, 1922, to March 17, 22.*that I last saw her alive on *March 17, 22.*and that death occurred, on the date stated above, at *9:25 P. M.*

The CAUSE OF DEATH\* was as follows:

*Pyometria*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *John J. Brown* M. D.19 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in death from Violent Causes,

state (1) Means and Nature of Injury, and (2) whether Accidental,

Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Chaney Md. 3/18/22*

20 UNDERTAKER

*Ernest Bailey Fulton*

ADDRESS

*Ernest Bailey Fulton*

Specimen should state statement of OCCUPATION

See instructions on back of certificates.

D 62515

HEALTH DEPARTMENT—CITY OF BALTIMORE D 62515

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

ST.:

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

WARD

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds

How long in U. S., if of foreign birth?

yrs.

mos.

ds

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,

or Divorced (write the word)

male

White

Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Mrs Fred Walke

6 DATE OF BIRTH (month, day, and year)

Jan. 13, 1871

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

51 2 4

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Traveling Salesman

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Pa.

10 NAME OF FATHER

Warren Walke

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Pa

12 MAIDEN NAME OF MOTHER

Cora Walke

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Pa

14

Informant  
(Address)

Mercy Hospital Records

15

Burial Permit Clerk

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 17, 22

17

I HEREBY CERTIFY, That I attended deceased from

March 13, 1922, to March 17, 22

that I last saw him alive on March 17, 1922

and that death occurred, on the date stated above, at 8:40 P. M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

CONTRIBUTORY

(Secondary)

(duration)

Pulmonary Edema

and cardiac failure

(duration)

6 hrs.

19 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

18 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Knorrville, Penna

3/18/22

20 UNDERTAKER

Joseph A. Taylor

ADDRESS

Sayette



D 62516

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62516

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 3 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Noal Willis(a) RESIDENCE. No. 242 S. Dallas StST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>Black</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
----------------------	---------------------------------	--

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1858

7 AGE <u>63</u>	Years <u>--</u>	Months <u>--</u>	Days <u>--</u>	If LESS than 1 day, hrs. or min.
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## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work Laborer(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Swift Creek,  
(State or country) South Carolina10 NAME OF FATHER Jacob Willis11 BIRTHPLACE OF FATHER (city or town) Unknown  
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)14 Informant Hospital Records,  
(Address) Municipal Hospital.15 Filed Robert P. Harrison,  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 19 2217 I HEREBY CERTIFY, That I attended deceased from  
February 18, 19 22, to March 17, 19 22,that I last saw him alive on March 16, 19 22and that death occurred, on the date stated above, at 3:00 A.M.

The CAUSE OF DEATH\* was as follows:

Urinary extravasation  
from ruptured ureter(duration) - yrs. 1 mos. -- ds.CONTRIBUTORY  
(Secondary)(duration) - yrs. -- mos. 1 ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? yes Date of Feb 18, 1922Was there an autopsy? yesWhat test confirmed diagnosis? Clinical findings &  
autopsy & Martiney M. D.(Signed) 3/17/22 Address) Municipal Hospital.\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

AsburyMarch 19 1922

20 UNDERTAKER

ADDRESS 1802John E. HendersonCommanPHYSICIANS should state Exact statement of OCCUPA-  
tion, so that it may be properly classified. See instructions on back of certificates.

81922

Barnes Clark

REVISED UNITED STATES STANDARD  
 REVISED UNITED STATES STANDARD  
 CERTIFICATE OF DEATH  
 Approved by U.S. Census and American Public Health Assoc.  
 (74019 126 of 110)

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Planter, Physician, Compositor, Architect, Engineer, Civil engineer, Stationary engineer, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton mills; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At home; and children, not gainfully employed, as At school or At home. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as Servant, Cook, Housemaid, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: Former (retired, 6 yrs.). For persons who have no occupation whatever, write None.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles;

Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
 BY PHYSICIAN.

Due to gonococcus  
 infection

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62517

D 62517

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *318 N. Stricker.*ST. *19*

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Baby Johnson.*(a) RESIDENCE. NO. *318 N. Stricker.* ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*Caucasian*

5 Single, Married, Widowed, or Divorced (write the word)

*Infant*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *March 15, 1922*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. *2 1/2* or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country) *Maryland.*10 NAME OF FATHER *Thomas Johnson.*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Ann Arundel.*12 MAIDEN NAME OF MOTHER *Lena Davis.*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore*  
(State or country) *Maryland.*14 Informant *Thomas Johnson*(Address) *318 N. Stricker St.*15 Filed *Robert P. Harrison,*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 17, 1922*

17

I HEREBY CERTIFY, That I attended deceased from *March 15, 1922* to *March 17, 1922*, that I last saw her *dead* on *March 17, 1922*, and that death occurred, on the date stated above, at *3.20 P. M.* The CAUSE OF DEATH\* was as follows:*Summer haze of the newborn.*

(duration) yrs. mos. ds.

CONTRIBUTORY *Unknown*  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis? *Examination*(Signed) *J. J. Rogers*, M. D., 19 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Wm. Auburn Cem.* *Mar 18, 1922*

20 UNDERTAKER

ADDRESS

*E. W. Price**Baltimore*  
*903 Calumet*

R 18 1922

Burial Permit Clerk

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 62518

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62518

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1234 E. Preston ST., 9 WARD)

## 2. FULL NAME

Augusta Emmel

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE No.

1234 E Preston

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds.How long in U. S., if of foreign birth? 69 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

## 5a If married, widowed, or divorced

(or) WIFE of

Conrad Emmel

## 6 DATE OF BIRTH (month, day, and year)

May 10<sup>th</sup> 1845

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

76107

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Germany

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Augusta Pichler

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

## 14

Informant (Address)

Mrs Mary Zimmerman  
1234 E. Preston St

## 15

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 17 1922

## 17

I HEREBY CERTIFY That I attended deceased from March 1 1922 to March 16 1922.that I last saw her alive on March 16 1922and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart Disease(duration) 8 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Geo. J. Gorman M. D.

(Address)

1107 Lexington Bld

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## 20 UNDERTAKER

Jerusalem Lutheran Cemetery  
George Schilling & Sons

## DATE OF BURIAL

March 20<sup>th</sup> 1922

## ADDRESS

7126 E. Monument St

PHYSICIANS should state Exact statement of OCCUPATION is very important. See instructions on back of certificates.

18 1922



D 62519

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62519

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2413 Harlem Ave* ST. *16* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Charles Augustus Ray Rice*(a) RESIDENCE. NO. *2413 Harlem Ave* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *79* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

*Male White Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1843*

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

*29*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired Clerk*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Clerk*

(c) Name of employer

*Baltimore City*

9 BIRTHPLACE (city or town) (State or country)

*Baltimore, Md*

10 NAME OF FATHER

*Connie Ray Rice*

11 BIRTHPLACE OF FATHER (city or town)

*Suzerden*

12 MAIDEN NAME OF MOTHER

*Mother Coleman*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore*

14

*James F B Schuyler*  
(Address) *2413 Harlem Ave*

15

Filed *Robert P. Harrison*

Registrar

8 1922

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 17* 19 *22*

17 I HEREBY CERTIFY, That I attended deceased from

*February 19<sup>th</sup> 1922, to March 12<sup>th</sup> 1922*that I last saw him alive on *March 16<sup>th</sup> 1922*and that death occurred, on the date stated above, at *6.30 a* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Interstitial Nephritis*(duration) *2* yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

*Uraemia*  
(duration) — yrs. — mos. *one* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of —Was there an autopsy? *No*What test confirmed diagnosis? *Urinary*(Signed) *Stephen F. Greenman* M. D.*March 17, 1922* (Address) *1227 Lafayette Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Catholic Cem* *3-21 1922*

20 UNDERTAKER

ADDRESS

*Martin Hayes Son* *827 W North*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62520

D 62520

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1007 Pennsylvania Ave ST. 17 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. 1007 Pennsylvania ST. WARD.

(Usual place of nboe)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Thom Hill6 DATE OF BIRTH (month, day, and year) May 17 18537 AGE Years 66 Months 10 Days 0 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mr. K. P. Knapp9 BIRTHPLACE (city or town) Charlottesville Va (State or country)10 NAME OF FATHER Nicholas Carter11 BIRTHPLACE OF FATHER (city or town) Charlottesville Va (State or country)12 MAIDEN NAME OF MOTHER Lucy Cousens13 BIRTHPLACE OF MOTHER (city or town) Charlottesville Va (State or country)14 Informant Jane Thom Hill (Address) 1007 Pennsylvania Ave15 Filed March 17 1922 Registrar Samuel T. Hensley

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 192217 I HEREBY CERTIFY, That I attended deceased from Feb. 22, 1922, to March 12, 1922.that I last saw him alive on March 16, 1922.and that death occurred, on the date stated above, at 7:05 A. m.

The CAUSE OF DEATH\* was as follows:

Uterine Carcinoma  
(duration) yrs. 8 mos. ds.CONTRIBUTORY Age - etc  
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical  
(Signed) William H. Wright M. D.(Address) 1709 Pressman St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 18 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62521

## CERTIFICATE OF DEATH.

D 62521

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *108 Palapasco Ave* ST. *27* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. *108 Palapasco Ave* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *27* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Col.* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *none*6 DATE OF BIRTH (month, day, and year) *Jan 18 1865*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *47*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Portblock*(b) General nature of industry, business, or establishment in which employed (or employer) *140*(c) Name of employer *Self*9 BIRTHPLACE (city or town) (State or country) *Tennessee*10 NAME OF FATHER *Don't know* *unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *unknown*12 MAIDEN NAME OF MOTHER *unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *unknown*14 Informant *Nancy Sinner* (Address) *108 Palapasco Ave*15 Filed *19* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Feb 10 1922*17 I HEREBY CERTIFY, That I attended deceased from *Feb 8/22*, 19 *22*, to *Feb 10*, 19 *22*that I last saw him alive on *Feb 10*, 19 *22*and that death occurred, on the date stated above, at *10<sup>00</sup> A* m.

The CAUSE OF DEATH\* was as follows:

*Alb. Pneumonia*

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death? *108 Palapasco Ave*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Smear*(Signed) *W. C. Sinner* M. D.(Address) *Arden*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Not Buried* *3/19 1922*

20 UNDERTAKER ADDRESS

*Samuel Sinner* *Arden*MARGIN RESERVED FOR BINDING  
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 18 1922

Burial Permit (Mark)

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or Intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Acute nephritis  
due to influenza  
Probably broncho  
pneumonia*



MARGIN RESERVED FOR BINDING  
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

62522

117 D 62522

1-PLACE OF DEATH  
CITY OF BALTIMORE: (NO) JOHNS HOPKINS HOSPITAL ST. 17 WARD)

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Gant

(a) RESIDENCE. NO. 602 W. Lenox ST., WARD.  
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.  
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE Years 60 Months 2 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

(c) Name of employer At home

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER John Rainbow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER William

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1922

17 I HEREBY CERTIFY, That I attended deceased from March 15<sup>th</sup>, 1922, to March 16<sup>th</sup>, 1922, that I last saw her alive on March 16<sup>th</sup>, 1922,

and that death occurred, on the date stated above, at 12<sup>15</sup> m.

The CAUSE OF DEATH\* was as follows:  
general peritonitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY Acute appendicitis rupture (Secondary) (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of March 15, 1922

Was there an autopsy? yes

What test confirmed diagnosis? Operation and autopsy

(Signed) John Brown M. D.

. 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn DATE OF BURIAL 3/20 1922

20 UNDERTAKER Samuel T. Hensley ADDRESS 5780 Biddle

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62523

## CERTIFICATE OF DEATH.

90 D 62523  
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 579 Mosher ST., 14 WARD)

2-FULL NAME Samuel Waters

(a) RESIDENCE NO. 579 Mosher ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith Waters

6 DATE OF BIRTH (month, day, and year) 7/25/1875

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 47

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer 070  
(b) General nature of industry, business, or establishment in which employed (or employer) Photographs  
(c) Name of employer Bacros

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edith Waters  
(Address) 579 Mosher St.

15

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17/1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 6th, 1922 to Mar. 13th, 1922, that I last saw him alive on Mar 13, 1922, and that death occurred, on the date stated above, at 4.00 p. m. The CAUSE OF DEATH\* was as follows:  
Organic Heart disease  
(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? House

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) A. L. Ellis, M. D.

3/16/1922 Address 928 Madison

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL St. Ambrose DATE OF BURIAL 3/18/1922

20 UNDERTAKER Samuel H. Biddley ADDRESS 378 W

MAR 18 1922

Registrar

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62524

## CERTIFICATE OF DEATH.

31 D 62524

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 769 Vine

ST.: H WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mary L. Holmes

## (a) RESIDENCE. NO.

769 Vine

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

5 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

Caucasian

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Unknown

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45-

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

041

(c) Name of employer

Lilli White

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

William Carter

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Camp 60 Va

## 12 MAIDEN NAME OF MOTHER

Mary Carter

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

## 14

Informant (Address)

Hessie Holmes 769 Vine St.

## 15

Filed

19

Registrar

MAR 18 1922

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 10 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

March 8, 1922, to March 10, 1922,

that I last saw her alive on

March 10, 1922,

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

3 months (duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

No Thoma

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Whalley, M. D.

15, 1922 Address 1350 S. 11th Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Crematorium 1922

## 20 UNDERTAKER

ADDRESS

Brown &amp; Leland Schuch

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1099 Bks.

D 62525

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62525

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydeham Hospital* WARD)

2-FULL NAME *Janet Goldmacher*

(a) RESIDENCE. NO. *210 S. Bruce* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *April 25-1914*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *0 11 23*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto. Md.* (State or country)

10 NAME OF FATHER *Carroll Goldmacher*

11 BIRTHPLACE OF FATHER (city or town) *Balto. Md.* (State or country)

12 MAIDEN NAME OF MOTHER *Irene Hauf*

13 BIRTHPLACE OF MOTHER (city or town) *Balto. Md.* (State or country)

14 Informant (Address) *See 15*

15 Filed *Robert P. Harrison,*

Registrar

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 17 1922*

17 I HEREBY CERTIFY, That I attended deceased from *March 15*, 19*22*, to *March 17*, 19*22*, that I last saw her alive on *March 17*, 19*22*, and that death occurred, on the date stated above, at *7:30 P* m. The CAUSE OF DEATH\* was as follows:

*Laryngeal diphtheria*

(duration) yrs. mos. *4* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *3* ds.

18 Where was disease contracted *at home* if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Culture for* (Signed) *B. H. Harrison* M. D.

*3/18/22* (Address) *Sydeham Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Catholic Cemetery* *Mar 18*

20 UNDERTAKER

ADDRESS

*H. H. Harrison* *1729 W. Pratt*

MAR 18 1922



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62526

## CERTIFICATE OF DEATH.

REGISTERED NO.

129 D 62526

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Moore(a) RESIDENCE. NO. NoneST. None WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
----------------------	---------------------------------	--

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1356

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
<u>65</u>	<u>--</u>	<u>--</u>	<u>--</u>	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workLaborer(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)New York

10 NAME OF FATHER

Unknown11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Unknown

12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Unknown14 Informant Hospital Records,  
(Address) Municipal Hospital.15 Filed Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1922

17 I HEREBY CERTIFY, That I attended deceased from  
February 22 19 22. to March 15 19 22.  
that I last saw him alive on March 15 19 22.  
and that death occurred, on the date stated above, at 5:15 P.M.

The CAUSE OF DEATH\* was as follows:

Chronic nephritis(duration) 1 yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. M. Reed M. D.6/16/23 Address Municipal Hospital.\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

19

20 UNDERTAKER

ADDRESS

Commissioner Health,

MAR 15 1922

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

MAR 18 1922

D 62527

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62527

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 17 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Fields(a) RESIDENCE. No. 528 Walnut St.ST. 17 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds. , How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>Black</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
----------------------	---------------------------------	--

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1883

7 AGE <u>38</u>	Years	Months	Days	If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workLaborer(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) Virginia10 NAME OF FATHER Henry D. Fields11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Virginia12 MAIDEN NAME OF MOTHER Mary Payne13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Virginia14 Informant Hospital Records,  
(Address) Municipal Hospital.15 Filed Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 19 22

17 I HEREBY CERTIFY, That I attended deceased from  
March 4, 19 22 to March 14, 19 22.  
that I last saw him alive on March 14, 19 22.  
and that death occurred, on the date stated above, at 4:00 A.M.

The CAUSE OF DEATH\* was as follows:

Pulmonary embolismCONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

3/14/22 (Address) Municipal Hospital.\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITALMAR 14 1922

20 UNDERTAKER

Commissioner Health,

ADDRESS

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

MAR 18 1922

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No further history*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62528

## CERTIFICATE OF DEATH.

D 62528

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No.

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Bessie Buscman

(a) RESIDENCE. NO.

(Usual place of abode)

Washington D.C. ST.

WARD.

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If nonresident give city or town and State)

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

7

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

widow

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

unknown 1860

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

66

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Russia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Russia

14

Informant  
(Address)Jack Lewis  
1439 E. Baltimore St.

15

Filed

Robert D. Harrison

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/17 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 10, 1922, to March 17, 1922

that I last saw her alive on March 17, 1922

and that death occurred, on the date stated above, at 9:30 A. M.

The CAUSE OF DEATH\* was as follows:

Coronary Decompensation  
Chr. Myocarditis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

Diabetes Mellitus

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

H. Zinberg

M. D.

3/17, 1922 (Address)

Hebrew Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Washington D.C.

3/18 1922

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E. Baltimore St.

MARGIN RESERVED FOR BINDING  
 N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 18 1922



MARGIN RESERVED FOR BINDING  
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1545-46  
D 62529

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62529

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7 WARD)

2-FULL NAME

French Slusher

(a) RESIDENCE NO.

(Usual place of abode)

Willis, Floyd Co.

WARD Virginia

Length of residence in city or town where death occurred

1 year yrs. 0 mos. 0 ds.

How long in U. S., if of foreign birth?

0 yrs. 0 mos. 0 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 26<sup>th</sup> 1914

7 AGE Years 7 Months 9 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Va.

10 NAME OF FATHER

Sylvanus Slusher

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va.

12 MAIDEN NAME OF MOTHER

Ida Helton

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va.

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed

19

Robert F. Harrison

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17<sup>th</sup> 1922

17

I HEREBY CERTIFY, That I attended deceased from March 16<sup>th</sup> 1922 to March 17<sup>th</sup> 1922, that I last saw him alive on March 17<sup>th</sup> 1922, and that death occurred, on the date stated above, at 10<sup>45</sup> P. M.

The CAUSE OF DEATH\* was as follows:

Hydrocephalus

(duration) yrs. 3 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 17<sup>th</sup>

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

F. L. Rickett

M. D.

19

(Address)

Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Willis

3/18 19 22

20 UNDERTAKER

ADDRESS

Jack Lewis

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62530

## CERTIFICATE OF DEATH.

REGISTERED NO.

62530

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1312 Light

ST.

WARD)

## 2-FULL NAME

Rebecca Bogelsang

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE. NO.

1312 Light

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

78

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Widowed

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Jan 5 - 1844

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

78

2

1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

## 10 NAME OF FATHER

John Colwell

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14 Informant

(Address)

Mr C. Stillman 1312 Light St

## 15 Filed

Robert F. Harrison

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Mar 16 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Mar 12 1922, to Mar 16 1922

that I last saw her alive on Mar 16 1922

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH\* was as follows:

Acute Bronchitis

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. 5 ds.

Bronchopneumonia

(duration) yrs. mos. 2 ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Wm. S. Hager

M. D.

(Address)

1319 Light St

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Western Am

3/18/ 1922

## 20 UNDERTAKER

## ADDRESS

John F. Hager Lang

1318 Light

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 18 1922

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AR 18 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62531

D 62531

CERTIFICATE OF DEATH

PLACE OF DEATH

Margaret E. Mulligan

REGISTERED NO. C

CITY OF BALTIMORE (No.

1620 Harford Ave

ST.

WARD

FULL NAME

Margaret E. Mulligan

(Residence in Baltimore: No.

804 N. Calvert

St.

yrs.

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

COLOR OR RACE

White

SINGLE,  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

Single

DATE OF BIRTH

2/14

(Month)

(Day)

1869

(Year)

AGE

53

yrs.

1

mos.

3

ds.

If LESS than  
1 day, hrs.  
or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Dressmaker

069

BIRTHPLACE  
(State or country)

Baltimore Md

PARENTS

NAME OF FATHER

Thomas Mullikin

BIRTHPLACE OF FATHER  
(State or country)

Baltimore Md

MAIDEN NAME OF MOTHER

Unknown

BIRTHPLACE OF MOTHER  
(State or country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Philip Kueberth

(Address)

1618 Harford Ave

15

Robert P. Harrison,

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

March

(Month)

17

(Day)

1922

(Year)

I HEREBY CERTIFY, That I attended deceased from

March 3, 1922, to March 17, 1922.

that I saw her alive on March 15, 1922

and that death occurred, on the date stated above, at 12:10 P.M.

The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis

(Duration) 1 yrs. 6 mos. ds

Contributory  
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) J. H. Smith

M. D.

March 17, 1922 (Address) 1112 Calvert St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Patrick's Cemetery

3/20, 1922

20. UNDERTAKER

ADDRESS

George J. Ruth

1735 Harford Ave

MARGIN RESERVED FOR BINDING  
B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 62532 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62532

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 Gorsuch ave ST. 9 WARD)

2-FULL NAME Nellie M. Wharton

(a) RESIDENCE. No. 712 Gorsuch ave ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

William T. Wharton Jr

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 36 7 16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

William T. Bayless

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Maryland

12 MAIDEN NAME OF MOTHER

Lillie M. Linthicum

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

North Carolina

14

Informant (Address)

Mrs William T. Bayless 712 Gorsuch ave

15

By

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 18<sup>th</sup>, 1921, to March 5, 1922, that I last saw her alive on March 15, 1922, and that death occurred, on the date stated above, at 6-30 P.M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Test of Sputum

(Signed) Francis D. McCarroll, M.D.

. 19 (Address) 416 E. North ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Olivet Cemetery March 20 1922

20 UNDERTAKER

ADDRESS

Chas. G. Black 742 W. North ave

MAR 18 1922



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificate.

MAR 1

D 62533

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *St. Helena* (City) *26* Ward)

2-FULL NAME

(Residence in Baltimore: No. *St. Helena* St.; yrs., *28* mos. .... ds.)

Registered No. C. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-Single *Married* (Write the word.)

6-DATE OF BIRTH.

(Month) (Day) (Year)

7-AGE.

*78* yrs. .... mos. .... ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Seaman*  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country) *Balti Md*

PARENTS.

10-NAME OF FATHER.

*Not known*

11-BIRTHPLACE OF FATHER.

(State or Country) *.. ..*

12-MAIDEN NAME OF MOTHER.

*.. ..*

13-BIRTHPLACE OF MOTHER.

(State or Country) *.. ..*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs Alice Cliffe*

(Address) *Red Gate Creek Md*

15-

Filed

8 1922

Robert P. Harrison,

Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

*March 17* 192*2*  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY that I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquiry* find that said deceased came to *his* death *on the day stated above.*

The CAUSE OF DEATH was as follows:

*Senility*  
*Arterio Sclerosis*

(Duration) yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. .... mos. .... ds.

(Signed) *G. L. B. Bades* M. D.

(Coroner) *Mar 18/22 143 No. Bray*

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

*National Cem* *March* 192*2*

20-UNDERTAKER.

*William Cook* ADDRESS *502 E. North Ave*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Itks.

D 62534

(New) HEALTH DEPARTMENT—CITY OF BALTIMORE 40 62534

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Josephs Hospital*)

WARD)

2-FULL NAME *Ferdinand Nero*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. *unknown*

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *unknown* yrs. mos.

ds. How long in U. S., if of foreign birth? *7* yrs. *7* mos. *7* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *?*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *unknown*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *about 28*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Carpenter*  
*015*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Italy*

10 NAME OF FATHER

*unknown*

PARENTS

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*unknown*

12 MAIDEN NAME OF MOTHER

*unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*unknown*

14

Informant (Address)

*Carpenters Union Local 715 N. Eutaw St*

15

*Robert F. Harrison,*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-16-22*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan. 27, 1922, to March 16, 1922,*

that I last saw him alive on *March 16, 1922,*

and that death occurred, on the date stated above, at *7 P* m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma of stomach*

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *yes* Date of *Feb. 1, 1922*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. H. Ponte, Jr.* M. D.

. 19 (Address) *St Joseph's Hosp.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Cross Bayford*

*3/2/22*

20 UNDERTAKER

ADDRESS

*William Cook*

*502 E. North Ave*

APR 18 1922

Burial Permit Clerk.

D 62535

## HEALTH DEPARTMENT—CITY OF BALTIMORE, 001 D 62535

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1449 Henry ST. 24 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. 1449 Henry ST. 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Catherine Callahan

6 DATE OF BIRTH (month, day, and year) Jan 3, 1881

7 AGE

70

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14

Informant (Address)

Phillip J. Callahan 1449 Henry St.

15

Filed

19

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17, 1922

17

I HEREBY CERTIFY, That I attended deceased from Mar 10, 1922, to Mar 17, 1922,

that I last saw him alive on Mar 17, 1922,

and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 7 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No

Date of

Was there an autopsy? No

What test confirmed diagnosis?

Signed: H. K. Campbell, M. D.

18, 1922 (Address) 1644 Hanover St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

W. C. Work

3/22/22 502 E North

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 18 1922

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bk.

62536 62536  
HEALTH DEPARTMENT—CITY OF BALTIMORE  
CERTIFICATE OF DEATH.  
74 D 62536

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 Russell St Mt Wmns ST. 1 WARD)

2-FULL NAME *Stephen Thomas Hebron*

(Residence in Baltimore: No. 14 Russel St

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *Cold* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widower*

6-DATE OF BIRTH. *6* *10*, 18*49*  
(Month) (Day) (Year)

7-AGE. *73* yrs. *2* mos. *23* da. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *none*  
(b) General nature of industry, business, or establishment in which employed (or employer) *000*

9-BIRTHPLACE, (State or Country), *Ind*

10-NAME OF FATHER, *Moses Hebron*

11-BIRTHPLACE OF FATHER (State or Country), *Ind*

12-MAIDEN NAME OF MOTHER *Roda Harrison*

13-BIRTHPLACE OF MOTHER (State or Country), *Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Bessie Gai Flier*

(Address) *14 Russell St. Mt. Wmns*

15-MAR 19 1922 ROBERT R. KRAUTER,

Filed *1922* 191 Burial Permit *1922*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *3* *17*, 19*22*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *3.11.* 19*22*, to *3.11* 19*22*, that I saw him alive on *3-15* 19*22*, and that death occurred, on the date stated above, at *1-10 a.m.*

The CAUSE OF DEATH\* was as follows:

*Paralysis*

(Duration) *6* mos. *6* da.

CONTRIBUTORY *Hemorrhage of Brain*  
(Secondary)

(Duration) *2* yrs. *6* mos. *6* da.

(Signed) *W. H. Hall* M. D.

*3.17.1922* (Address) *14 Russell St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *3* yrs. *2* mos. *23* da. In the State *3* yrs. *2* mos. *23* da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*Ourp Meade Junction* *Mar. 19, 1922*

20-UNDERTAKER ADDRESS *1303*

*John H. Hall* *Truman St.*



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62537

CERTIFICATE OF DEATH.

900 62537

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1620 N. Lexington ST.; 19 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1620 N. Lexington ST.; 40 yrs., mos., ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

F.

4-COLOR OR RACE,

Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widow

6-DATE OF BIRTH,

March 4, 1860  
(Month) (Day) (Year)

7-AGE,

77 yrs., 0 mos., 13 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housework  
070

9-BIRTHPLACE,

(State or Country),

N. Va.

10-NAME OF FATHER,

John Williams

11-BIRTHPLACE OF FATHER

(State or Country),

N. Va.

12-MAIDEN NAME OF MOTHER

Mary Williams

13-BIRTHPLACE OF MOTHER

(State or Country),

N. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

E. S. Williams

(Address)

2344 McCulloch St.

15-

MAR 9 1922

ROBERT R. KRAUTER,

Filed

191

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 17, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan. 15 1922, to March 17 1922,

that I saw her alive on March 17 1922,

and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH\* was as follows:

Initial Regurgitation

(Duration) 2 yrs., 2 mos., 13 ds.

CONTRIBUTORY (Secondary)

(Duration) 2 yrs., 2 mos., 13 ds.

(Signed)

J. M. Hays M. D.  
318, 19122 (Address) 513 N. Liberty St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Laurel St.

DATE OF BURIAL,

March 19, 1922

20-UNDERTAKER

L. H. Broadwell Son

ADDRESS

108 N. Mountg.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62538

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

62538

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *734 Genz* ST. *17* WARD)

2-FULL NAME

(Residence in Baltimore: No. *734 Genz*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. *4* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *male* 4-COLOR OR RACE, *colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *single* (Write the word.)

6-DATE OF BIRTH, *March 14, 1922* (Month) (Day) (Year)

7-AGE, *4* yrs., *4* mos., *4* ds. If LESS than 1 day, *hrs.* or *mins.* *4*

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *none* (b) General nature of industry, business, or establishment in which employed (or employer). *Infants*

9-BIRTHPLACE. (State or Country). *Balto. Md.*

10-NAME OF FATHER. *Laurence Henderson*

11-BIRTHPLACE OF FATHER (State or Country). *Md.*

12-MAIDEN NAME OF MOTHER. *Bessie Campbell*

13-BIRTHPLACE OF MOTHER (State or Country). *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Drew Fuller*

(Address) *734 Genz St.*

*MAR 19 1922* ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *March 17, 1922* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

*gust* and that said deceased came to *his* death (Inquest, au-

topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Patient fractured pelvis*

(Duration) *4* yrs., *4* mos., *4* ds.

CONTRIBUTORY (Secondary) *fractured pelvis*

(Duration) *4* yrs., *4* mos., *4* ds.

(Signed) *J. D. Henderson* M. D. (Coroner.)

*March 18, 1922* (Address) *2802 Edmondson St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *4* yrs., *4* mos., *4* ds. In the *4* yrs., *4* mos., *4* ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Int. Auburn Cem.* DATE OF BURIAL, *3/19/22*

20-UNDERTAKER *Jas. M. Skinner* ADDRESS *1625 C. Madison St.*

D 62539

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1119 E Pratt*

ST.

WARD)

## 2-FULL NAME

*Fannie Hurwitz*(a) RESIDENCE NO. *1119 E Pratt*

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female white**Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Unknown*

7 AGE

Years

Months

Days

If LESS than 1 day, .... hrs. or .... min.

*20**4**10**—**—*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

*037*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md*

10 NAME OF FATHER

*Samuel Davidson*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Russia*

12 MAIDEN NAME OF MOTHER

*Fannie Davidson*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Russia*

14

Informant (Address)

*Jacob Davidson 1119 E Pratt St*

15

Informant (Address)

*ROBERT K. KRAUTER,**MAR 19 1922**Burial Permit Clerk*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 18 1922*

17

I HEREBY CERTIFY, That I attended deceased from *February 1921* to *Mar 18 1922*that I last saw him alive on *Mar 17 1922*and that death occurred, on the date stated above, at *3.30 a. m.*

The CAUSE OF DEATH\* was as follows:

*Pulmonary T. B.*

(duration)

yrs. *13*

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs. *2*

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*What test confirmed diagnosis? *clinical*

(Signed)

*A. F. Reis*

M. D.

Mar 18 1922 (Address)

*24 S. Mary*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Hebrew Rosedale Cemetery March 19 1922*

20 UNDERTAKER

ADDRESS *1127 E**Max Gerson**Baltimore*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 62540

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 62540

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *420 N. Euter* ST., *5* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. *420 N. Euter* ST., *5* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *40* yrs. mos. ds.

How long in U. S., if of foreign birth? *40* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Salomon Margolis*

6 DATE OF BIRTH (month, day, and year) *Unkn*

7 AGE *65 yrs* Years Months Days *LESS than* 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House wife*

(b) General nature of industry, business, or establishment in which employed (or employer) *037*

(c) Name of employer

9 BIRTHPLACE (city or town) *Russia* (State or country)

10 NAME OF FATHER *Israel David Meister*

11 BIRTHPLACE OF FATHER (city or town) *Russia* (State or country)

12 MAIDEN NAME OF MOTHER *Fruma Isaac*

13 BIRTHPLACE OF MOTHER (city or town) *Russia* (State or country)

14 Informant *Jack Lewis* (Address) *1439 E. Balt St*

15 *MAR 19 1922* ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 17 19 22*

17

I HEREBY CERTIFY, That I attended deceased from *Jan 22 1922* to *Mar 17 19 22*, that I last saw her alive on *Mar 16 19 22*

and that death occurred, on the date stated above, at *9:30 P. m.*

The CAUSE OF DEATH\* was as follows:

*Diabetes Mellitis*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Luigi D. DiStefano* M. D.

*Mar 18 1922* (Address) *407 N. Euter St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Hehrin Rosedale*

*3/19 1922*

20 UNDERTAKER

ADDRESS

*Jack Lewis 1439 E. Balt St*



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

6-9-19—H. P. Co.—1000 Bks.

62541

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

62541  
4+62541

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1925 Ridgwood ST., 15 WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maranda Lucretia Wilson

(a) RESIDENCE. No. 1925 Ridgwood ST., 15 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced, HUSBAND of John H. Wilson (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) March 1-1862

7 AGE Years 60 Months 0 Days 16 If LESS than 1 day, 0 hrs. 0 min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co Md. (State or country)

10 NAME OF FATHER Reverend H. Phillips

11 BIRTHPLACE OF FATHER (city or town) Carroll Co Md. (State or country)

12 NAME OF MOTHER Elizabeth Bales

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co Md. (State or country)

14 Informant Mrs. Bowen (Daughter) (Address) 1925 Ridgwood

15 MAR 19 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-17 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1922 to March 17, 1922 that I last saw him alive on March 17, 1922 and that death occurred, on the date stated above, at 2:40 P.M.

The CAUSE OF DEATH\* was as follows:

Curcumbur of liver.

(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) Exhaustion yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. C. Allen, M. D.

3/18/22 address 2737 W. Monmouth

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Deer Park M. E. Cem. (Cannell) 3/20 1922

20 UNDERTAKER ADDRESS

Horace H. Burgee 363 Fall Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62542

CERTIFICATE OF DEATH. D 62542

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 173 Falls Road ST. 13 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 173 Falls Road ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruben Ellett

6 DATE OF BIRTH (month, day, and year) Sept 1869

7 AGE Years 52 Months 6 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home job

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co Md (State or country)

10 NAME OF FATHER John Williams

11 BIRTHPLACE OF FATHER (city or town) Balto. Co Md (State or country)

12 MAIDEN NAME OF MOTHER Ellen Mowrey

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co Md (State or country)

14 Informant D S Williams (Address) 173 Falls Rd.

15 MAR 19 1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1922 to Mar 16, 1922, that I last saw her alive on Mar 16, 1922, and that death occurred, on the date stated above, at 4 a m. The CAUSE OF DEATH\* was as follows:

Myocardial insufficiency - Hypertension (duration) yrs. 17 mos. ds.

CONTRIBUTORY (Secondary) Parenchymatous nephritis (duration) yrs. 6 mos. ds.

18 Where was disease contracted Place of death if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) E. S. Short M. D.

Address 1812 Dupont Highway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Iron Church, Green Mar 19 1922

20 UNDERTAKER A S Marshall 3539 Fall Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62543

CERTIFICATE OF DEATH.

90 D 62543

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2675 Hampden Ave. ST. 12 WARD)

2-FULL NAME

(a) RESIDENCE. No. 2675 Hampden Ave. ST. 12 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

(If nonresident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Blanche M. Norris

6 DATE OF BIRTH (month, day, and year)

Jan 6 - 1876

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

46

2

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. City Md.

10 NAME OF FATHER

W. M. Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt. Co. Md.

12 MAIDEN NAME OF MOTHER

Florence O. Shaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Co. Md.

14

Informant (Address)

Florence O. Norris 2675 Hampden Ave.

15

MAR 19 1922

ROBERT R. KRAUTER, Registrar

Local Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 17 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 4, 1922, to March 17, 1922,

that I last saw him alive on March 6, 1922,

and that death occurred, on the date stated above, at 3 A. M.

The CAUSE OF DEATH\* was as follows:

Valvular disease of heart - atherosclerosis - auricular fibrillation. I am a physician.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. R. Krauter, M. D.

(Address) 3547 Chestnut Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Marys Hampden Mar 20 1922

20 UNDERTAKER

ADDRESS

W. S. Marshall 2539 Fall Road

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62544

## CERTIFICATE OF DEATH.

D 62544

### 1-PLACE OF DEATH

City of BALTIMORE: (No. *724 S. Bond St.* St. *3* Ward)

Registered No. C.....

### 2-FULL NAME

(Residence in Baltimore: No. *724 S. Bond St.* St.; yrs. .... mos. .... ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-Single, Married, Widowed, or Divorced, (Write the word.) *X*

6-DATE OF BIRTH *July 27-1921* (Month) (Day) (Year)

7-AGE *7* yrs. *27* mos. *27* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Balt Md*

PARENTS.  
10-NAME OF FATHER, *Paul Janicke*  
11-BIRTHPLACE OF FATHER, (State or Country), *Poland*  
12-MAIDEN NAME OF MOTHER, *Mary Konfrath*  
13-BIRTHPLACE OF MOTHER, (State or Country), *Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Janicke*  
(Address) *724 S. Bond*

15- *MAR 19 1922* ROBERT R. KRAUTER, Burial Permit Clerk.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *March 18*, 192*2* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *investigation* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *investigation* (Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*congenital debility*  
(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(Signed) *July 31 1922* (Duration) .... yrs. .... mos. .... ds. (Coroner) *Charles R.*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*Holy Rosary Mar 20 1922*

20-UNDERTAKER, ADDRESS

*114 Calverton Rd*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62545

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1536 Halbrook Street ST. 9 WARD)

REGISTERED NO. D 62545

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Collier

(Residence in Baltimore: No. 1536 Halbrook St. St.; 50 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widowed

6-DATE OF BIRTH, April 30, 1897 (Month) (Day) (Year)

7-AGE, 64 yrs., mos. ds. It LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Street Porter (b) General nature of industry, business, or establishment in which employed (or employer), 686

9-BIRTHPLACE, (State or Country), Ireland

10-NAME OF FATHER, Robert Collier

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Nellie Doyle

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert N. Collier

(Address) 1536 Halbrook St.

15-MAR 19 1922 ROBERT R. KRAUTER, Registrar

Filed 191

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 17, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 9, 1916, to March 17, 1917, that I saw him alive on March 16, 1917, and that death occurred, on the date stated above, at ... m. The CAUSE OF DEATH\* was as follows:

Pneumonia (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Pulmonary Nephritis

(Signed) William H. Grady, M. D. (Address) 3038 N. ...

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral

DATE OF BURIAL, Mar. 20, 1917

20-UNDERTAKER, J. C. Windfield

ADDRESS, 94 ...

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62546

## CERTIFICATE OF DEATH.

REGISTERED

D 62546

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1909 Free Ave ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Gabriel

(a) RESIDENCE. NO. 1909 Free Ave ST. 20 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Wht 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13-1867

7 AGE Years 54 Months 8 Days 4 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

10 NAME OF FATHER Joseph Gabriel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Johanna Hanke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Frank Gabriel (Address) 124 Coal St. Baltimore, Md.

15 MAR 19 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 19 22

17 I HEREBY CERTIFY, That I attended deceased from

March 3, 19 22, to March 16, 19 22,

that I last saw him alive on March 16, 19 22,

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH\* was as follows:

Cardiac Stenosis  
& Chronic Int. Nephrit  
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary disease  
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. Theo. K. K. K. M.D.

(Address) 22 3450 Fulton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

New Cathedral Mar 20 19 22

20 UNDERTAKER ADDRESS

Geo. L. Schwab 2101 Park Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62547

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C

1-PLACE OF DEATH

City of BALTIMORE: (No. *Franklin Square Hospital* St. *19* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1430 Hollins* St. *37* yrs. *37* mos. *3* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *white* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Single*

6-DATE OF BIRTH, *Oct 12 1882* (Month) (Day) (Year)

7-AGE, *39* yrs. *4* mos. *3* ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Sales Lady* (b) General nature of industry, business, or establishment in which employed (or employer), *Dry Good Store*

9-BIRTHPLACE, (State or Country), *Balt Md*

PARENTS. 10-NAME OF FATHER, *John Gray* 11-BIRTHPLACE OF FATHER, (State or Country), *Balt Md* 12-MAIDEN NAME OF MOTHER, *Barbara Stahl* 13-BIRTHPLACE OF MOTHER, (State or Country), *Balt Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs T.C. Drake* (Address) *1420 Hollins St*

15- *MAR 19 1922* ROBERT R. KRAUTER, Registrar. Burial Permit *1420*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Mar 17 1922* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) had that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH\* was as follows: *3rd Burns on chest & abdomen accident, clothes caught fire while warming herself by gas stove* (Duration) *1 1/2* yrs. *1* mos. *1* da.

CONTRIBUTORY (Secondary) (Duration) *1* yrs. *1* mos. *1* da. (Signed) *James M. Bardon* M. D. (Coroner) *Mar 19 1922* (Address) *700 E Chase St*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death *1430 Hollins St* In the State *Md* yrs. *37* mos. *3* ds.

Where was disease contracted, if not at place of death? *1430 Hollins St* Former or usual residence *1430 Hollins St*

19-PLACE OF BURIAL OR REMOVAL, *Riverton Park* DATE OF BURIAL, *Mar 21 1922*

20-UNDERTAKER, *George J. Smith* ADDRESS *1000 W 12th St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62548

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 W Franklin ST.; 18 WARD)2-FULL NAME Jacob H Currell(Residence in Baltimore: No. 1123 W Franklin St.; 21 yrs., 1 mos., 1 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

M

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Dec161849

(Month)

(Day)

(Year)

7-AGE,

7281

yrs.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None9-BIRTHPLACE,  
(State or Country),Balto

10-NAME OF FATHER,

Wickman11-BIRTHPLACE OF FATHER  
(State or Country),Maryland

12-MAIDEN NAME OF MOTHER

Wickman13-BIRTHPLACE OF MOTHER  
(State or Country),Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Currell(Address) 1123 W Franklin St

15-

Filed MAR 19 1922 ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Mar171922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Mar 22 1921, to Mar 17 1922,that I saw him alive on Mar 17 1922,and that death occurred, on the date stated above, at 2:15 P.m.

The CAUSE OF DEATH\* was as follows:

Chronic Brights(Duration) 5 yrs., 1 mos., 1 ds.CONTRIBUTORY  
(Secondary)None(Duration) 1 yrs., 1 mos., 1 ds.(Signed) H. B. Currell M. D.Mar 17, 1922 (Address) 1123 W Franklin St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs., 1 mos., 1 ds. In the State 1 yrs., 1 mos., 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St Olivet CemeteryMar 20, 1922

20-UNDERTAKER

ADDRESS 1123 W Franklin StGeorge J. Smith1123 W Franklin St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1900 Bks.

D 62549

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

62549  
90 D 62549

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 Linden Ave ST. 14 WARD)

2-FULL NAME Annie Greer

REGISTERED NO. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 1801 Linden Ave ST. \_\_\_\_\_ WARD. \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single  
5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) Aug 28 1887

7 AGE 34 Years 7 Months \_\_\_\_\_ Days \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ or \_\_\_\_\_ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) Ireland  
(State or country)

10 NAME OF FATHER John Greer

11 BIRTHPLACE OF FATHER (city or town) Ireland  
(State or country)

12 MAIDEN NAME OF MOTHER Went

13 BIRTHPLACE OF MOTHER (city or town) Ireland  
(State or country)

14 Informant Miss Belle Greer

(Address) 1801 Linden Ave

15 MAR 19 1922 ROBERT H. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 7 1921 to Mar 17 1922, that I last saw him alive on Mar 17 1922, and that death occurred, on the date stated above, at 8 A. M.

The CAUSE OF DEATH\* was as follows:  
Heart & Pulmonary Disorders  
Met of Myocarditis (Senile)  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted \_\_\_\_\_ If not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? Pathology

(Signed) \_\_\_\_\_, M. D.

, 12 (Address) 1133 Linden Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Landon Park DATE OF BURIAL Mar 20 1922

20 UNDERTAKER George J. Smith ADDRESS 1000 4th Ave N

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62550  
1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 1808 Dukeland Ave. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James S. Adams

(Residence in Baltimore: No. 1808 Dukeland Ave. St.; 14 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

M

4-COLOR OR RACE,

W

5-SINGLE, Married  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

May 24, 1857  
(Month) (Day) (Year)

7-AGE,

64 yrs., 9 mos., 23 ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

Automobile Upholsterer

9-BIRTHPLACE,  
(State or Country),

Ohio

10-NAME OF FATHER,

John Adams

11-BIRTHPLACE OF FATHER  
(State or Country),

Pa

12-MAIDEN NAME OF MOTHER

Mary Shay

13-BIRTHPLACE OF MOTHER  
(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma S. Adams

(Address) 1808 Dukeland Ave.

15-

Filed MAR 19 1922 ROBERT R. KRAUTER,

Burial Permit Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 17, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 7, 1922, to March 16, 1922,

that I saw him alive on March 16, 1922,

and that death occurred, on the date stated above, at 1.20 p.m.

The CAUSE OF DEATH\* was as follows:

Acute Myocarditis

(Duration) ... yrs. ... mos. 12 ds.

CONTRIBUTORY  
(Secondary)

Tuberculosis

(Duration) ... yrs. ... mos. 2 ds.

(Signed) Fred C. Lewis M. D.

March 17, 1922 (Address) 2516 Penna Ave.

\*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

March 20, 1922

20-UNDERTAKER

George J. Smith

ADDRESS 1000 N.

Fayette St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## Remarks

*Had abscessed tooth. Extracted. Toxemia from tooth  
no further history*

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

*lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septichæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

<i>Abortion,</i>	<i>Cellulitis,</i>	<i>Childbirth,</i>	<i>Convulsions,</i>
<i>Hæmorrhage,</i>	<i>Gastritis,</i>	<i>Erysipelas,</i>	<i>Meningitis,</i>
<i>Gangrene,</i>	<i>Miscarriage,</i>	<i>Necrosis,</i>	<i>Peritonitis,</i>
<i>Phlebitis,</i>	<i>Pyæmia,</i>	<i>Septicæmia,</i>	<i>Tetanus.</i>

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (if induced), whether death is directly or indirectly due to the same.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62551

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 723 W Lexington St.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

M. C. McElroy

(Residence in Baltimore: No. 723 W Lexington St.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

June 14, 1869

7-AGE,

53

Yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Pattern maker

9-BIRTHPLACE, (State or Country),

Bath City

10-NAME OF FATHER,

M. C. McElroy

11-BIRTHPLACE OF FATHER (State or Country),

Bath City

12-MAIDEN NAME OF MOTHER

Mary Hanson

13-BIRTHPLACE OF MOTHER (State or Country),

Bath City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

W. B. McElroy

(Address)

1545 N. Filmore St.

15-

MAR 19 1922

ROBERT R. KRAUTER,

101

Bureau of Health

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 17, 1922

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH was as follows:

Inhalation of Phosphorus Gas  
Surgically  
inadvertently

(Duration)

2 hrs

CONTRIBUTORY (Secondary)

Acute Alcoholism

(Duration)

Yrs. mos. ds.

(Signed)

W. B. McElroy

(Coroner.)

3. 19, 1922

(Address) 117 W. Lexington St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death. Yrs. mos. ds. State. Yrs. mos. ds.

Where was disease contracted, if not at place of death.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

Western

DATE OF BURIAL,

March 21, 1922

20-UNDERTAKER

H. B. Branning

ADDRESS

800 N. E. St.



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62552

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 334 Cheltenham Ave ST. 17 WARD)

2-FULL NAME Alice Lambert Shaffer

(a) RESIDENCE. NO. 334 Cheltenham Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Harry C. Shaffer

6 DATE OF BIRTH (month, day, and year) Sept 30 1871

7 AGE Years 50 Months 5 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md.

10 NAME OF FATHER Samuel J. Lambert

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md.

12 MAIDEN NAME OF MOTHER Catherine J. Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Del.

14 Informant Harry C. Shaffer (Address) 334 Cheltenham Ave

15 REGISTRAR ROBERT R. KRAUTER, Registrar

MAR 19 1922

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1922

17 I HEREBY CERTIFY, That I attended deceased from March 11 1922, to March 17 1922,

that I last saw her alive on March 17 1922,

and that death occurred, on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) George J. M. D.

317/22 (Address) 4016 25th St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mount Olivet Cemetery Mar 20 1922

20 UNDERTAKER

John F. Denny

ADDRESS

715 Light St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62553

## CERTIFICATE OF DEATH.

REGISTERED D 62553

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin St. Hospital ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 909 So. Paca St. St. 6 yrs., - mos., - ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)  
Mar.

6-DATE OF BIRTH,

May, 8, 1877.  
(Month) (Day) (Year)

7-AGE,

44 yrs., - mos., - ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife  
837

9-BIRTHPLACE, (State or Country),

Pa.

10-NAME OF FATHER,

Emanuel Bach

11-BIRTHPLACE OF FATHER (State or Country),

Pa.

12-MAIDEN NAME OF MOTHER

Flora Moore

13-BIRTHPLACE OF MOTHER (State or Country),

Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Maurice Vess

(Address)

#909 S. Paca St.

15-

Filed MAR 19 1922 ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Mar, 16, 1922.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Mar - 6 - 1922, to Mar - 16 - 1922,that I saw her alive on Mar - 16 - 1922,and that death occurred, on the date stated above, at 10:35 P.m.

The CAUSE OF DEATH\* was as follows:

Lymphatic Leukemia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

8/16, 1922 (Address) Franklin St. Hospital

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 909 So. Paca

19-PLACE OF BURIAL OR REMOVAL,

Linden Park Cem.

DATE OF BURIAL,

MAR. 20, 1922

20-UNDERTAKER

F.A. Trause & Son

ADDRESS

703 Hanover St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62554

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 62554

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 807 Light St. St. 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Patrick J. Murray.

(Residence in Baltimore: No. 805 Light St. St. 60 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 4-COLOR OR RACE, 5-Single, Married, Widowed, or Divorced, (Write the word.)  
Male. White. Widowed.

6-DATE OF BIRTH, March 17th, 1854. 1.  
(Month) (Day) (Year)

7-AGE, 67 yrs. 11 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work..... Laborer.  
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Ireland.

10-NAME OF FATHER, Martin Murray.

11-BIRTHPLACE OF FATHER, (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER, Margaret Waldon.

13-BIRTHPLACE OF MOTHER, (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Murray. (daughter)

(Address) 805 Light St.

15-

FILE

MAR 19 1922

ROBERT R. KRAUTER,

Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 16th, 1922, 192.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to death topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

Organic disease of the heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. H. Reinhardt, M. D. (Coroner)

March 17, 1922 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

New Cathedral Cem. Mar 20, 1922

20-UNDERTAKER, ADDRESS

H. H. Krauter & Co. 703 Hanover St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 MAT 1500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62555

CERTIFICATE OF DEATH.

D 62555

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1129 Hamover ST., 23 WARD)

2. FULL NAME

Ellen G. Sweeney

(a) RESIDENCE No.

1129 Hamover

ST., \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

\_\_\_\_\_ yrs.

\_\_\_\_\_ mos.

\_\_\_\_\_ ds.

How long in U. S., if of foreign birth?

70 yrs.

\_\_\_\_\_ mos.

\_\_\_\_\_ ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Patrick T. Sweeney

6 DATE OF BIRTH (month, day, and year)

Nov 22-1849

7 AGE

Years

Months

Days

If LESS than

72

3

25

1 day, \_\_\_\_\_ hrs  
or \_\_\_\_\_ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Ireland

10 NAME OF FATHER

Terence Chrystal

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant

Thomas Sweeney

(Address)

1129 Hamover St.

15

MAR 19 1922

ROBERT A. KRAUTER  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5<sup>th</sup> 1922

17

I HEREBY CERTIFY, That I attended deceased from

June 16<sup>th</sup> 1921 to March 17<sup>th</sup> 1922

that I last saw her alive on March 16<sup>th</sup> 1922

and that death occurred, on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH\* was as follows:

Arterio-sclerosis

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY  
(Secondary)

Cerebral Hemorrhage

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted

if not at place of death?

At place of death

Did an operation precede death?

No Date of \_\_\_\_\_

Was there an autopsy?

No

What test confirmed diagnosis?

Physical Findings

(Signed)

Harry Heibel

3/19, 1922 (Address) 1224 Hamover St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral Cem

DATE OF BURIAL

Mar 20 1922

20 UNDERTAKER

F. C. France & Son

ADDRESS

1037 Hamover



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 62556

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62556

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Kropp

(a) RESIDENCE. No. 917 S. Elwood Ave  
(Usual place of abode)

ST. 1 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Yrs. 1 Mos. 1

ds. How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 22 1851

7 AGE Years 70 Months -- Days 23 If LESS than 1 day, hrs. -- or min. --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardener

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany  
(State or country)

10 NAME OF FATHER Henry Kropp

11 BIRTHPLACE OF FATHER (city or town) Germany  
(State or country)

12 MAIDEN NAME OF MOTHER Caroline Leeser

13 BIRTHPLACE OF MOTHER (city or town) Germany  
(State or country)

14 Informant Hospital Records,  
(Address) Municipal Hospital.

15 MARI 9 1922 ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1922

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1922, to March 17, 1922, that I last saw him alive on March 16, 1922, and that death occurred, on the date stated above, at 7:55 A.M.  
The CAUSE OF DEATH\* was as follows:

Chronic myocarditis

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

3/17/22 Address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Schwartz  
Joklan & Joklan

Ind 20 1922  
Eager

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62557.

## CERTIFICATE OF DEATH.

45 D 62557.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2811 Riggs Ave. ST. 16 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rosabelle Eliz. Mary Otto.

(a) RESIDENCE. No. 2811 Riggs Ave. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 7 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John F. Otto

6 DATE OF BIRTH (month, day, and year) Aug 15<sup>th</sup> 1866

7 AGE Years 55 Months 7 Days 2 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Henry D. Reinhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary Betz

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

J. Norman Otto 2811 Riggs Ave

15

MAR 19 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3. 17 1922

17

I HEREBY CERTIFY, That I attended deceased from

11-21-21, 19, to 3. 17, 1922,

that I last saw her alive on 3. 16, 1922,

and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH\* was as follows:

Intestinal Carcinoma

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1647 Arington St.

Did an operation precede death? yes. Date of 2.2.22.

Was there an autopsy? no

What test confirmed diagnosis? Clinical-Microscopic

(Signed) Philip B. Fowler, M. D.

3.18, 1922 Address 1432 William St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Gen., March 20 1922

20 UNDERTAKER

ADDRESS 1034

J. Schloman &amp; Son

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62558

## CERTIFICATE OF DEATH.

D 62558

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *653 N Lee St* ST. *22* WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

*William E Schaffle*

### (a) RESIDENCE NO.

*653 N Lee St* ST. *22* WARD

(Usual place of abode)

### WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *3* yrs. *8* mos. *22* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

#### 3 SEX

*Male*

#### 4 COLOR OR RACE

*White*

#### 5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

#### 5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

#### 6 DATE OF BIRTH (month, day, and year)

*June 25, 1918*

#### 7 AGE

*3*

Years

*8*

Months

*22*

Days

If LESS than 1 day, hrs. or min.

#### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

#### 9 BIRTHPLACE (city or town) (State or country)

*Balto., Md.*

#### 10 NAME OF FATHER

*Wm. Schaffle*

#### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balto., Md.*

#### 12 MAIDEN NAME OF MOTHER

*Rosa V. Kintel*

#### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balto., Md.*

#### 14

Informant (Address)

*Mrs Wm E Schaffle 653 N Lee St*

#### 15

*MAR 19 1922*

ROBERT R. KRAUTER

Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/16/22*

#### 17

I HEREBY CERTIFY, That I attended deceased from *Feb 27, 1922* to *March 16, 1922*, that I last saw him alive on *March 16, 1922*, and that death occurred, on the date stated above, at *6 P* m. The CAUSE OF DEATH\* was as follows:

*Septic sore throat*

#### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *17*  
*dilatation of heart*  
(duration) yrs. mos. ds. *1*

#### 18 Where was disease contracted If not at place of death?

Did an operation precede death? *no*

Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Sepsis following throat*

(Signed)

*Dr. A. O. Downie* M. D.

(Address)

*102 E West St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

#### 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

#### DATE OF BURIAL

*Cathedral C. M.*

*Mar 20 1922*

#### 20 UNDERTAKER

#### ADDRESS

*Margaret G. Flynn*

*1422 Light St*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62559

CERTIFICATE OF DEATH.

D 62559

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 Cooks ST.: 24 WARD)

2-FULL NAME

Catherine Schulz-Benezovitch

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 1209 Cooks ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Michael Benezovitch

6 DATE OF BIRTH (month, day, and year)

June 3, 1873

7 AGE

Years

Months

Days

IF LESS than

1 day. hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(own)

037

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Schulz

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Catherine Schulz

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Michael Benezovitch  
1209 Cooks St.

15

MAR 19 1922

ROBERT R. KRAUTER  
Registrar

Sanitary Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16, 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 8, 1922, to March 16, 1922.

that I last saw him alive on March 12, 1922.

and that death occurred, on the date stated above, at 9 A. M.

The CAUSE OF DEATH\* was as follows:

Influenza

(duration) yrs. mos. ds. 8

CONTRIBUTORY (Secondary)

Acute dilatation of heart

(duration) yrs. mos. ds. 1/2

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

H. S. Murr, M. D.

4/6, 1922 (Address)

801 N. E. Street

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Stanislaus Cem. Mar 20 1922

20 UNDERTAKER

ADDRESS

Margaret S. Flynn 1422 Right



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

45 D 62560

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST. 7 WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Elizabeth Mackenzie

(a) RESIDENCE NO. 183 Belmont ST. Ward Tall River Mass  
(Usual place of abode)

Length of residence in city or town where death occurred unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced  
HUSBAND  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 1<sup>st</sup> 1852

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
69 4 19

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mass.

10 NAME OF FATHER John C. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Rhode Island

12 MAIDEN NAME OF MOTHER Jane E Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass.

14 Informant JOHNS HOPKINS HOSPITAL (Address) Record

15 MAR 19 1922 ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9<sup>th</sup> 1922

17 I HEREBY CERTIFY, That I attended deceased from March 11<sup>th</sup> 1922 to March 19<sup>th</sup> 1922 that I last saw him alive on March 19<sup>th</sup> 1922 and that death occurred, on the date stated above, at 5:00 a.m.

The CAUSE OF DEATH\* was as follows:  
CARCINOMA OF RECTUM

(duration) — yrs. 3 mos. — ds.  
CONTRIBUTORY INTESTINAL OBSTRUCTION  
(Secondary) (duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? YES Date of 3-15-22

Was there an autopsy? YES

What test confirmed diagnosis? —

(Signed) John L. Donsey, M. D.  
, 19 (Address) 1 H. H.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Tall River Mass. DATE OF BURIAL Mar 19 1922

20 UNDERTAKER Henry H. Jenkins & Sons ADDRESS McCulloch Orchard

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62561

57  
D 62561  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 330 E 25th ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. 330 E. 25thST. 12 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 450 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. B. Kelly6 DATE OF BIRTH (month, day, and year) Apr 8 18457 AGE Years 76 Months 11 Days — If LESS than 1 day, hrs. — or min. —

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland10 NAME OF FATHER Laurance Roach11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland12 MAIDEN NAME OF MOTHER don't know13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ire.

## 14

Informant Per. J. J. McNamee (Address) 330 E. 25th

## 15

MART 9 1922

ROBERT R. KRAUTER,  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 19 2217 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to March 16, 19 22, that I last saw her alive on March 10, 19 22 and that death occurred, on the date stated above, at 11 P. m.  
The CAUSE OF DEATH\* was as follows:Diabetes Mellitus(duration) 3 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) J. J. McNamee, M. D.3/18/22 (Address) 839 O. Ellwood Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Kenneth A. L. Bern. 3-20 19 22

## 20 UNDERTAKER

## ADDRESS

J. J. Moran E. B. 104

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 62562

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62562

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Green &amp; Lombard ST. 12 WARD)

2-FULL NAME

John Garrett

(a) RESIDENCE. No.

1620 Charles? Janau ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

colored

5 Single, Married, Widowed,

or Divorced (write the word)

infant

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 29 1920

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

1

10

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Infant

9 BIRTHPLACE (city or town).  
(State or country)

Balt. Md

10 NAME OF FATHER

John Garrett

11 BIRTHPLACE OF FATHER (city or town)

Md

(State or country)

12 MAIDEN NAME OF MOTHER

Berlah Read

13 BIRTHPLACE OF MOTHER (city or town)

Md

(State or country)

14

Informant  
(Address)

Hospital Records

15

MAR 20 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 17 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 6 1922 to March 17 1922

that I last saw him alive on March 17 1922

and that death occurred, on the date stated above, at 7:00 P.M.

The CAUSE OF DEATH\* was as follows:

Broncho-pneumonia  
(terminal)

(duration)

yrs.

mos.

ds.

3?

CONTRIBUTORY  
(Secondary)

Rickets Malnutrition

(duration)

yrs.

mos.

ds.

1

6

3

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? 7+

What test confirmed diagnosis?

Signs &amp; Symptoms

(Signed)

Geo. E. Wells

M. D.

19

(Address)

University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

not auturna

Mar 20 1922

20 UNDERTAKER

Joseph A. Farrell

ADDRESS

2017 Rialto

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rhs.

D 62563

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43 D 62563

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2847 W. Lafayette Ave. ST., 16 WARD)

2. FULL NAME Edward D. Kenna

(a) RESIDENCE NO. 2847 W. Lafayette Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Laura Kenna

6 DATE OF BIRTH (month, day, and year)

4/25/60

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

62

11

-

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Foreman in 186

(b) General nature of industry, business, or establishment in which employed (or employer)

Water Dept

(c) Name of employer

Balto City

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

John J. Kenna

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Mrs Laura Kenna 2847 W. Lafayette Ave.

15

MAR 20 1922

ROBERT K. KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/16/22

17

HEREBY CERTIFY, That I attended deceased from Mar 5, 1921, to Mar 16, 1922

that I last saw him alive on Mar 16, 1922

and that death occurred, on the date stated above, at 2:25 P. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Esophagus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank N. Hillis M. D.

19 (Address) 2838 Edmond St. Balto

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Bonnie Bral

20 UNDERTAKER

J. J. Zahay & Sons

DATE OF BURIAL

3/20/22

ADDRESS

1318 Light



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 62564

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62564

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 647 W. Redwood ST., WARD)

2-FULL NAME

August Schellenberger

(a) RESIDENCE NO.

647 W. Redwood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

41 yrs.

— mos.

— ds.

How long in U. S., if of foreign birth?

41 yrs.

— mos.

— ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of

or WIFE of

Anna Schellenberger

6 DATE OF BIRTH (month, day, and year)

Dec. 17, 1882

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

69

3

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Shoemaker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Not Known

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Not Known

14

Informant (Address)

Mr. Michael Schellenberger 1509 W. Milton Ave.

15

MAR 20 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 19, 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 19, 1922, to March 19, 1922.

that I last saw him alive on March 18, 1922.

and that death occurred, on the date stated above, at 4:25 P. M.

The CAUSE OF DEATH\* was as follows:

Senile dementia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

20, 1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL

DATE OF BURIAL

Holy Redeemer Cemetery

March 22, 1922

20 UNDERTAKER

ADDRESS

Henry Hoeckel

1301 E. Bay St.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62565

CERTIFICATE OF DEATH.

10 D 62565

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1606 N. Bethel* ST., *8* WARD)

2-FULL NAME

(a) RESIDENCE NO. *1606 N. Bethel* ST., *8* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Yrs. Mos. Ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *August 5, 1920*

7 AGE Years *1* Months *7* Days *14* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country)

10 NAME OF FATHER *James P. McFee*

11 BIRTHPLACE OF FATHER (city or town) *Balt.* (State or country)

12 MAIDEN NAME OF MOTHER *Catherine J. Saffery*

13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country)

14 Informant *Mr. James P. McFee* (Address) *1606 N. Bethel St.*

15 *MAR 20 1922* ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 19, 1922*

17 I HEREBY CERTIFY, That I attended deceased from *March 8, 1922*, to *March 19, 1922*, that I last saw him alive on *March 18, 1922*, and that death occurred, on the date stated above, at *10 A.* m.

The CAUSE OF DEATH\* was as follows:

*Laryngeal Diphtheria, Diphtheria Pneumonia, & Cardiac Paralysis*

(duration) yrs. mos. *11* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *11* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Clinical*

(Signed) *R. O. Carmon*, M. D.

*3-19-22* (Address) *1701 N. Caroline St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
*Holy Cross Cemetery Shopton Rd.* DATE OF BURIAL *March 20, 1922*

20 UNDERTAKER *Henry Howard Lee* ADDRESS *1301 E. Egan St.*

D 62566

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62566

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST. 13 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Krüss(a) RESIDENCE. No. 3613 Hickory Ave

ST. \_\_\_\_\_ WARD. \_\_\_\_\_

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

----

6 DATE OF BIRTH (month, day, and year)

1857

7 AGE

Years

Months

Days

If LESS than  
1 day, \_\_\_\_ hrs.  
or \_\_\_\_ min.

64

--

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## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town).  
(State or country)

Baltimore,

Maryland

10 NAME OF FATHER

Peter Krüss

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER Anna Fletcher

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant  
(Address)

Hospital Records,

Municipal Hospital.

15

MAR 20 1922

ROBERT K. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 14 1922, to March 17 1922,

that I last saw him alive on March 16 1922,

and that death occurred, on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH\* was as follows:

Diphtheria

CONTRIBUTORY  
(Secondary)

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(duration) 2 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis?

(Signed)

I. D.

3/17/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral

Mar 21 1921

20 UNDERTAKER

Franklin H. Leach

ADDRESS

3613 Hickory Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62567

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *148* ST. *1* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *Ridge Croft Rd (Overlea)* St. *148* yrs. *1* mos. *1* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Female*

## 4-COLOR OR RACE,

*White*

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)

*Married*

## 6-DATE OF BIRTH,

*Mar 10*, 190*0*  
(Month) (Day) (Year)

## 7-AGE,

*22*

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

*Home 037*

(b) General nature of industry, business, or establishment in which employed (or employer).

*none*

## 9-BIRTHPLACE, (State or Country).

*Baltimore*

## 10-NAME OF FATHER,

*Mr Miller*

## 11-BIRTHPLACE OF FATHER (State or Country).

*Yon Co*

## 12-MAIDEN NAME OF MOTHER

*Sylvia Cott*

## 13-BIRTHPLACE OF MOTHER (State or Country).

*Baltimore*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Wm Hermann*

(Address)

*Ridge Croft Rd*

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*3* / *18*, 19*22*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*3/17* 19*22*, to *3/18* 19*22*that I saw her alive on *3/18* 19*22*and that death occurred, on the date stated above, at *6:30* m.

The CAUSE OF DEATH\* was as follows:

*Myocardial Infarction*(Duration) *1* yrs. *1* mos. *1* ds.

## CONTRIBUTORY (Secondary)

*hypertension*(Duration) *1* yrs. *1* mos. *1* ds.(Signed) *W. H. Hermann* M. D.191... (Address) *2631 N. Liberty St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*Baltimore* *Mar 21*, 19*22*

## 20-UNDERTAKER ADDRESS

*Robt. J. Turner* *148*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 20 1922

ROBERT N. KRAUTER

Registrar.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62568

D 62568

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 10 W. Preston St. ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Duncan A. Gillies(a) RESIDENCE. No. 10 W. Preston St.ST. 11 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth 22 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown6 DATE OF BIRTH (month, day, and year) Aug. 9 18577 AGE Years 64 Months 7 Days 10 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Nova Scotia (State or country)10 NAME OF FATHER Archibald Gillies11 BIRTHPLACE OF FATHER (city or town) Scotland (State or country)12 MAIDEN NAME OF MOTHER Katharine Mc Clellan13 BIRTHPLACE OF MOTHER (city or town) Scotland (State or country)14 Informant Mr. Gillies (Address) 1506 Light St.15 MAR 20 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

16 DATE OF DEATH (month, day, and year) March 19 192217 I HEREBY CERTIFY, That I attended deceased from 3/8/22, 1922, to 3/18/22, 1922, that I last saw him alive on 3/18/22, 1922, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH\* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY Nephritis (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? Date of

Was there an autopsy? 2-2-22What test confirmed diagnosis? 2-2-22(Signed) C. W. Waters M. D.

394. Preston St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

New Cathedral Cem 3/21 1922

20 UNDERTAKER ADDRESS

J. Hew Mc Gully 130 E. Fort.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state exact statement of OCCUPATION. AGE should be stated EXACTLY. PHYSICIANS should state exact statement of OCCUPATION. See instructions on back of certificates.

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Chronic myocarditis*  
*Chronic interstitial*  
*nephritis*

39 Dr. R. T. M.

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUR-  
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUR-  
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62569

CERTIFICATE OF DEATH.

90 D 62569

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1051 W. Fayette ST. 18 WARD)

2-FULL NAME Edward Lavallee

(a) RESIDENCE. NO. 1051 W. Fayette ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Cromwell Lavallee

6 DATE OF BIRTH (month, day, and year) Feb. 6, 1851

7 AGE Years 71 Months 1 Days 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Self

9 BIRTHPLACE (city or town) Quebec (State or country) Canada

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Quebec (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Canada (State or country)

14 Informant Ella Cromwell Lavallee (Address) 1051 W. Fayette St.

MAR 20 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 19 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1922, to Mar 19, 1922, that I last saw him alive on Mar 18, 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyd M. D.

3-20-1922 Address 602 Bohmer Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Jean Port Jole, Canada Mar 20 1922

20 UNDERTAKER ADDRESS

Wm. J. Tickner & Sons North & pa

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62570

## CERTIFICATE OF DEATH.

D 62570

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1641 Ashland ST., 7 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Wm M. Caldwell

## (a) RESIDENCE NO.

1641 Ashland

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Anna Elizabeth Blum

## 6 DATE OF BIRTH (month, day, and year)

12/4/44

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

77315

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

Black009

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

## 9 BIRTHPLACE (city or town) (State or country)

1545 Mt

## 10 NAME OF FATHER

John Carroll School

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Mary M. School

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

## 14

Informant (Address)

Wm M. Caldwell  
3100 Presbury

## 15

ROBERT H. KRAUTER,  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

12/17/22 19

## 17

I HEREBY CERTIFY, That I attended deceased from

March 12, 1922, to March 17, 19that I last saw him alive on Mar 15, 19and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH\* was as follows:

Analysis

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm M. Caldwell, M. D., 19 (Address) 3100 Presbury

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

St. Oliver CemeteryMar 21, 22

## 20 UNDERTAKER

## ADDRESS

Wm. Truckner & SonNorth St.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Cerebral hemorrhage*

D 62571

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X 178 D 62571

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

38 yrs

8 mos

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Agnes Gertrude Dunn

6 DATE OF BIRTH (month, day, and year)

June 28, 1883

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

38 8 17

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Painter 050

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

Self

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore Md

10 NAME OF FATHER

Benj H Dunn

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Balto Md

12 MAIDEN NAME OF MOTHER

Emma E Bright

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Md

14

Informant  
(Address)The Trustees of the  
1616 Hollins St

15

MAR 20 1922

ROBERT R. KRAUTER

Burial Permit Clerk

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 17 19 22

17

I HEREBY CERTIFY, That I attended deceased from

March 7 1922 to March 17 19 22

that I last saw him alive on March 16 19 22

and that death occurred, on the date stated above, at 3:45 p m.

The CAUSE OF DEATH\* was as follows:

Acute Nephritis

(duration)

yrs.

mos 12 ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos 12 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

Physical

(Signed)

Edw J. Coolahan, M. D.

3/17/22 (Address)

24 N Fulton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Roudon Park

3/20/22

20 UNDERTAKER

ADDRESS

Wm J. Thacker 1201 North St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62572

## CERTIFICATE OF DEATH.

D 62572

### PLACE OF DEATH

CITY OF BALTIMORE (No. *17*)

FULL NAME *Lucy E. Walker*

(Residence in Baltimore: No. *843 Harlem Ave*)

REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1N.)

St.: yrs., mos. da.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *widow*

6-DATE OF BIRTH

*About Sept. 15, 1850*  
(Month) (Day) (Year)

7-AGE

*72 yrs. 4 mos. 2 da.*

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Home Duties*

9-BIRTHPLACE, (State or Country)

*Virginia*

10-NAME OF FATHER

*John O. Walker*

11-BIRTHPLACE OF FATHER

(State or Country)

*Md.*

12-MAIDEN NAME OF MOTHER

*Winters*

13-BIRTHPLACE OF MOTHER

(State or Country)

*Winters*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Paul Walker*  
(Address) *1404 Harlem Ave.*

15-

File **MAR 20 1922**

ROBERT R. KRAUTER

Burial Permit

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

*March 17, 1922*  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

*opsy* and that said deceased came to *his* death (Autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Fracture of femur (accidental)*

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

*Hypostatic Pneumonia*

(Duration) yrs. mos. da.

(Signed) *J. T. Hennessy* M. D.

(Coroner)

*March 15, 1922* (Address) *280 V. E. Howard Ave.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

*Woodlawn Cem*

DATE OF BURIAL

*Mar 20, 1922*

20-UNDERTAKER

*W. H. McInnes & Sons*

ADDRESS

*North Ave.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D<sup>3</sup> 62573

## CERTIFICATE OF DEATH.

119 D 62573

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 21 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Smith(a) RESIDENCE NO. 828 Burgundy ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred years mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

FemaleWhiteMarried

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John B. Smith

6 DATE OF BIRTH (month, day, and year)

June 12<sup>th</sup> ?

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

47

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Insurance

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

N.C.

10 NAME OF FATHER

Wm. A. Stratton

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

N.C.

12 MAIDEN NAME OF MOTHER

Frances Land

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

N.C.

14

Informant (Address)

JOHNS HOPKINS HOSPITALRecords

15

MAR 20 1922ROBERT R. KRAUTER,Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9<sup>th</sup> 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan. 30<sup>th</sup> 1922 to March 9<sup>th</sup> 1922.that I last saw her alive on March 9<sup>th</sup> 1922.and that death occurred, on the date stated above, at 120 P. M.

The CAUSE OF DEATH\* was as follows:

Retro-vaginal & Vesico-vaginal fistula(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Pyelonephrosis(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2-1-22Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Grant Edward M. D.19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Western View Mar 24 1922

20 UNDERTAKER

ADDRESS

Wm. Cook 502 E. North St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



D 62574

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62574

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 Cator Ave 9 WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 624 Cator

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

COLOR OR RACE Male White

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAR 20 1922

ROBERT R. KRAUTER

Burial Permit

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1922

17

I HEREBY CERTIFY That I attended deceased from

Dec 24 1921 to Feb 18 1922

that I last saw him live on Feb 18 1922

and that death occurred, on the date stated above, at 7 P. m.

THE CAUSE OF DEATH\* is as follows:

Rheumatic Deformity

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo W. Brown

119 1922 (Address) 1107 Lexington Bld

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62575 HEALTH DEPARTMENT—CITY OF BALTIMORE 181 D 62575  
CERTIFICATE OF DEATH  
1-PLACE OF DEATH *Ray View Hospital* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
City of BALTIMORE: (N) *Ray View Hospital*  
2-FULL NAME *Eugene E. Lickle*  
(Residence in Baltimore: No. *410 E Lafayette* St.; yrs. .... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS.  
3-SEX *Male* 4-COLOR OR RACE *White* 5-Single *Widowed*  
6-DATE OF BIRTH *July 13* 18*81*  
7-AGE *70* yrs. *8* mos. *4* ds. If LESS than 1 day, ... hrs. or ... min.?  
8-OCCUPATION:  
(a) Trade, profession, or particular kind of work *None*  
(b) General nature of industry, business, or establishment in which employed (or employer) *ooo*  
9-BIRTHPLACE (State or Country) *Md*  
PARENTS.  
10-NAME OF FATHER *Francis Lickle*  
11-BIRTHPLACE OF FATHER (State or Country) *Po*  
12-MAIDEN NAME OF MOTHER *Sarah Purro*  
13-BIRTHPLACE OF MOTHER (State or Country) *Md*  
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) *Mrs. Wm. Wundoor*  
(Address) *Ellicott City*  
15- *MAR 20 1922* ROBERT R. KRAUTER  
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.  
16-DATE OF DEATH *Mar 17* 19*22*  
17- I HEREBY CERTIFY that I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Inquest* and that said deceased came to *his* death *on the day stated above.*  
The CAUSE OF DEATH\* was as follows:  
*Accidental Asphyxia*  
*Swimming East*  
CONTRIBUTORY (Secondary) *None*  
(Signed) *G. C. Plade* M. D. (Coroner)  
(Address) *1436 Bmg*  
\*State the Disease Causing Death, or, in deaths from Violent Cause, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.  
18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).  
At place of death ... yrs. .... mos. .... ds. In the ... yrs. .... mos. .... ds.  
Where was disease contracted, if not at place of death?  
Former or usual residence  
19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL  
*Loudon Park* *Mar 20 1922*  
20-UNDERTAKER, ADDRESS  
*Wesford* *502 E North*

D 62576

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62576

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *138 S Carey*)ST.: *19* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. *138 S Carey*

(Usual place of abode)

ST.: *19* WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. *life* mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

PREPARED BY

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Mar. 17* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar 14*, 19*22*, to *Mar 17*, 19*22*.that I last saw him alive on *Mar 16*, 19*22*.and that death occurred, on the date stated above, at *8:30* a. m.

The CAUSE OF DEATH\* was as follows:

*Cardiac failure*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

*at residence*

Did an operation precede death?

*No* Date of

Was there an autopsy?

*No*

What test confirmed diagnosis?

*No*

(Signed)

19, 19*22* Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 62577

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62577

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *104 Calender* ST.; *18* WARD)2-FULL NAME *John A. Scharnagle*(Residence in Baltimore: No. *104 Calender* St.; *life* yrs., *life* mos., *life* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *W*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Mar.*6-DATE OF BIRTH *September 16, 1873*

(Month)

(Day)

(Year)

7-AGE *48**5* yrs., *27* mos., *27* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Barber*(b) General nature of industry, business, or establishment in which employed (or employer) *004*9-BIRTHPLACE, (State or Country), *73 acc*

PARENTS.

10-NAME OF FATHER, *Laurence Scharnagle*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Elizabeth Hess*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Marie J. Scharnagle*(Address) *104 Calender*

15-

MAR 20 1922 ROBERT R. KRAUTER,

Filed

191

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Mar 15, 1922*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Mar 10* 191*2*, to *Mar 15* 191*2*,that I saw h... alive on *Mar 15* 191*2*,and that death occurred, on the date stated above, at *9 P.* m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary tuberculosis*



D 62578

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62578

## CERTIFICATE OF DEATH. X 91-001

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland General Hospital* ST. *WARD*)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *William H. Morrison*(a) RESIDENCE NO. *Edgemere, Maryland* ST. *WARD*

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. *2* mos. *12* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of *Irene Morrison* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *Mar 1, 1891*7 AGE Years *31* Months Days *15* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Carpenter* 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Sparks Point* (State or country) *Maryland*10 NAME OF FATHER *Alvin H. Morrison*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *New York*12 MAIDEN NAME OF MOTHER *Christina Brown*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country) *Maryland*14 Informant *Maryland General Hospital* (Address)15 *MAR 2 0 1922* ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 17, 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan 5, 1922* to *March 17, 1922*, that I last saw him live on *March 17, 1922*, and that death occurred, on the date stated above, at *4:15 p.m.*

The CAUSE OF DEATH\* was as follows:

*Aneurysm of Femoral Artery (Right)* *OVER*(duration) yrs. *5* mos. ds.CONTRIBUTORY *Hemorrhage - Cardiac* (Secondary) *Failure* (duration) yrs. mos. *1* ds.18 Where was disease contracted if not at place of death? *Edgemere, Maryland*Did an operation precede death? *Yes* Date of *Jan 28, 1922*Was there an autopsy? *Yes*What test confirmed diagnosis? *Clinical*(Signed) *John W. M. M. D.*, 19 (Address) *Md. General Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Mount Carmel*

DATE OF BURIAL

*Mar 24, 1922*

20 UNDERTAKER

*John F. Denny*

ADDRESS

*715 Light*

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 62579

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

44 D 62579  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 22 WARD)2-FULL NAME William S. Snyder(a) RESIDENCE NO. 110 W. Lee ST., \_\_\_\_\_ WARD \_\_\_\_\_(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred 12 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Lydia Snyder6 DATE OF BIRTH (month, day, and year) Mar 13 / 18527 AGE Years 70 Months — Days 5 16 LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey10 NAME OF FATHER Peter Snyder11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey12 MAIDEN NAME OF MOTHER Allen Dohart13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey14 Informant (Address) JOHNS HOPKINS HOSPITAL15 MAR 20 1922 ROBERT R. KRAUTER Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 / 192217 I HEREBY CERTIFY, That I attended deceased from Feb. 27<sup>th</sup>, 1922 to March 18<sup>th</sup>, 1922, that I last saw him alive on March 18<sup>th</sup>, 1922, and that death occurred, on the date stated above, at 9:30 10 m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of the esophagus(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb 28<sup>th</sup>Was there an autopsy? yes Gastrostomy

What test confirmed diagnosis?

(Signed) J. F. Reed, M. D.19 (Address) Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

London Park Cemetery Mar 26, 1922

20 UNDERTAKER

ADDRESS

John F. Denny 715 Light St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62580

## CERTIFICATE OF DEATH.

D 62580

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 Jefferson ST., 6 WARD)

## 2. FULL NAME

(a) RESIDENCE No. 1819 Jefferson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

78 yrs. 9 mos. 23 ds.

How long in U. S., if of foreign birth?

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced

(or) WIFE of

late Harry C. Prouty

6 DATE OF BIRTH (month, day, and year)

May 26-43

7 AGE

Years

Months

Days

If LESS than

78

9

23

1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None job

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

City

10 NAME OF FATHER

John Chicholm

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant

(Address)

Caleb J. C. Prouty

1819 Jefferson

15

MAR 20 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/18 1922

17

I HEREBY CERTIFY, That I attended deceased from

Mar 17, 1922, to

Mar 18, 1922,

that I last saw her alive on

Mar 17, 1922,

and that death occurred, on the date stated above, at

11:30 P. M.

The CAUSE OF DEATH\* was as follows:

Hemiplegia

(duration) 3 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Paraplegia &amp; Asthenia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. G. Prouty, M. D.

19

(Address)

1804 E. Bayview St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Baltimore Cemetery

DATE OF BURIAL

3/21 1922

20 UNDERTAKER

Philip Herwig

ADDRESS

Orleans

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Apoplectic.*



D 62581

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62581

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1000 E Fayette ST., 5 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. 1000 E Fayette ST., 5 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown7 AGE Years 55 Months — Days — If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic(b) General nature of industry, business, or establishment in which employed (or employer) Spring Garden Shop(c) Name of employer Con. Gas. E. L. & P. Co.9 BIRTHPLACE (city or town) Beraria (State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)14 Informant Con. Gas. E. L. & P. Co. (Address) record15 MAR 20 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/18th, 192217 I HEREBY CERTIFY, That I attended deceased from March 1st, 1922, to March 14th, 1922,that I last saw him alive on March 14th, 1922,and that death occurred, on the date stated above, at 9 m.

The CAUSE OF DEATH\* was as follows:

MyocarditisC. K. U. J. Riley (duration) 5 yrs. 6 mos. ds.CONTRIBUTORY arteriosclerosis (Secondary) (duration) — yrs. — mos. ds.18 Where was disease contracted if not at place of death? —Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? —(Signed) Chas. H. Waters, M. D., 19 39 W. Preston St. (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Balto Cem.DATE OF BURIAL 3/20 192220 UNDERTAKER Philip HenryADDRESS 2016 Orleans

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62582

## CERTIFICATE OF DEATH.

D 62582

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1232 Greenmount Ave.* ST. *10* WARD)

## 2-FULL NAME

*Phillip Trupp*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

*1232 Greenmount Ave.* ST.

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *11* yrs. mos. ds. How long in U. S., if of foreign birth? *11* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Widowed*

## 5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*unknown 1897*

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*85*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired - 100*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Russia.*

## 10 NAME OF FATHER

*Nathan Trupp*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Russia*

## 12 MAIDEN NAME OF MOTHER

*Polly*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Russia*

## 14

Informant  
(Address)*Nathan Trupp*  
*1232 Greenmount Ave.*

## 15

Filed

*Mar 20 1922*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 19 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from  
*March 2*, 1922, to *March 19*, 1922,  
that I last saw him alive on *March 12*, 1922,  
and that death occurred, on the date stated above, at *8 pm.*

The CAUSE OF DEATH\* was as follows:

*General Arteriosclerosis*CONTRIBUTORY  
(Secondary)*several*  
(duration)

yrs.

mos.

ds.

*old age*

(duration)

yrs.

mos.

ds.

## 18 Where was disease contracted if not at place of death?

*none*

## Did an operation precede death?

*no*

Date of

## Was there an autopsy?

*no*

## What test confirmed diagnosis?

*Personal observation*

(Signed)

*J. W. Keown*, M. D.*Mar 19 1922* (Address) *1938 Linden Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Mehren Messing Run*

## DATE OF BURIAL

*3/20 1922*

## 20 UNDERTAKER

*Jack Lewis 1439 E. Balt. St.*

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62583

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1731 Braddish ave ST., 15 WARD)

2-FULL NAME Louis F. Gerson

(a) RESIDENCE NO. 1731 Braddish Ave ST., WARD  
(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed,  
or Divorced, (write the word) *Married*

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of *Mary E. Lucas*

6 DATE OF BIRTH (month, day, and year)                      /                      /                      48

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	—	—	

### 1 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... *Embroiderer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

**9 BIRTHPLACE** (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Russia*

12 MAIDEN NAME OF MOTHER *Johnson*

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *P. 100*

14 Informant *J. Lewis*  
(Address) *1411 E. 100th St.*

15 MAR 20 1922 ROBERT R. KRAUTER, Registrar  
Ducal Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/19 1922

17 I HEREBY CERTIFY, That I attended deceased from  
July 5, 1920, to Mch 19<sup>th</sup>, 1922.  
that I last saw him alive on Mch 19<sup>th</sup>, 1922.  
and that death occurred, on the date stated above, at 830 a.m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis of kidney  
Had kidney removed Jan 1/194  
(duration) ~~2~~ yrs. 18 mos. da.

CONTRIBUTORY (Secondary) Exhaustive + Exhaustive  
(duration) yrs. mos. 360

18 Where was disease contracted  
if not at place of death?.....

Did an operation precede death? yes Date of Jan 1921

**Was there an autopsy?**

What test confirmed diagnosis? <sup>720</sup>  
(Signed) Chas H Buber M. D.

Feb 20, 1922 (Address) J. W. Lafayette Co

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

20 UNDERTAKER

## 20 UNDERTAKER

Jack Lewis 1439 E. Balboa St

DATE OF BURIAL

3/20 1927

ADDRESS

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.; *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Phy. states possibly cancerous condition  
Lump not involved  
J. H. Hoops.  
Hypernephroma rt kidney.  
Cancerous. Operation at Hopkins  
for above



## HEALTH DEPARTMENT—CITY OF BALTIMORE D 62584

D 62584

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 527 East ST., 5 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Addie Timber(a) RESIDENCE NO. 527 East St. ST., 5 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word)Widowed5a If married, widowed, or divorced HUSBAND of John Timber WIFE of6 DATE OF BIRTH (month, day, and year) Jan 6, 18677 AGE Years 55 Months 7 Days 2 If LESS than 1 day, hrs. or min. 12

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) MD10 NAME OF FATHER John Brown11 BIRTHPLACE OF FATHER (city or town) (State or country) MD12 MAIDEN NAME OF MOTHER Sarah Jones13 BIRTHPLACE OF MOTHER (city or town) (State or country) MD14 Informant Dr. R. R. R. R. (Address) 527 E. East St15 Filed MAR 20 1922 Registrar J. H. R. R.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 192217 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1922, to March 18, 1922, that I last saw him alive on March 18, 1922, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of StomachCONTRIBUTORY (Secondary) transient (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted

if not at place of death? inDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physical signs(Signed) J. M. C. R. R., M. D.20, 1922 (Address) 111 E. East St

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Laurel CemeteryMarch 20 1922

20 UNDERTAKER

ADDRESS

George J. R. R. - 1235 Haeferd

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62585

D 62585

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1046 Shield alley ST. 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. 21 mos. 15 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

Male

## 4-COLOR OR RACE,

Colored

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

## 6-DATE OF BIRTH,

June 7, 1922  
(Month) (Day) (Year)

## 7-AGE,

1 yrs. 9 mos. 15 ds.

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country),

Ind.

## 10-NAME OF FATHER,

Richard Johnson

11-BIRTHPLACE OF FATHER  
(State or Country),

Va.

## 12-MAIDEN NAME OF MOTHER

Viola Sweeney

13-BIRTHPLACE OF MOTHER  
(State or Country),

SC.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

David Easton

(Address)

916 Pa. av

15-MAR 20 1922

Filed

191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

March 18, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

March 15, 1922, to March 18, 1922,

that I saw him alive on March 18, 1922,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. N. King, M. D.  
3-19, 1922 (Address) 651 Mt. Vernon St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Mt. Vernon Co. March 20, 1922

## 20-UNDERTAKER

## ADDRESS

David Easton 916 Pa. av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# Remarks

*Phy. could give no further history.*

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

*lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septichæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

*Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.*

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (if induced), whether death is directly or indirectly due to the same.

D 62586

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

46 D 62586

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal HospitalST.: 18 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Hall(a) RESIDENCE. No. 218 N. Amity

(Usual place of abode)

ST.: \_\_\_\_\_ WARD. \_\_\_\_\_

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced (write the word) widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) 18847 AGE 38 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)10 NAME OF FATHER John Brown11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md. (State or country)12 MAIDEN NAME OF MOTHER Ann Brown13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md. (State or country)14 Informant Daniel Carter (Address) 916 Pa15 Filed MAR 20 1922 Registrar J. E. H. H.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/18/22 1917 I HEREBY CERTIFY, That I attended deceased from 3/10/22, 19 to 3/18/22, 19that I last saw her alive on 3/18/22, 19and that death occurred, on the date stated above, at 2:00 P.m.

The CAUSE OF DEATH\* was as follows:

cancer of the uterus

(duration) ? yrs. mos. ds.

CONTRIBUTORY cachexia, secondary anemia (Secondary)

(duration) ? yrs. mos. ds.

18 Where was disease contracted ? if not at place of death?

Did an operation precede death? NO Date of \_\_\_\_\_Was there an autopsy? yes NOWhat test confirmed diagnosis? A.S. H. H. H. (Signed) \_\_\_\_\_, M. D., 19 (Address) Municipal Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Auburn Mar 24 1922

20 UNDERTAKER ADDRESS

Daniel Carter 916 Pa

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR- TION is very important. See instructions on back of certificates.



D 62587 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62587

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1308 Stricker ST. 15 WARD)

## 2. FULL NAME

William Green Jr.

## (a) RESIDENCE NO.

1308 Stricker

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Wife

6 DATE OF BIRTH (month, day, and year)

Oct 21 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5

12

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

Baby

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

William Green

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Carey Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

William Green 1308 N. Stricker

15

MAR 20 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18 1922

17

I HEREBY CERTIFY That I attended deceased from March 14 1922 to March 18 1922. that I last saw him alive on March 18 1922.

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:

Broncho-pneumonia

(duration) + yrs. + mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Charles E. Clark M. D.

1922 (Address) 1306 N. Stricker

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAT Mt. Auburn

DATE OF BURIAL

Mar 21 1922

20 UNDERTAKER

Edward Puggold

ADDRESS

1463 Carey St

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62588

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland General Hospital* WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Registered

MAR 20 1922

ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Mar 14, 1922, to Mar 17, 1922

that I last saw her alive on Mar 17, 1922

and that death occurred, on the date stated above, at 5 A. M.

The CAUSE OF DEATH\* was as follows:

Patent Foramen Ovale

(duration) yrs. mos. 2 1/2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Stanley W. Matthews, M. D.

19 (Address) Maryland General Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

HOPKINS HOSPITAL

20 UNDERTAKER

Commissioner Health

Per. W. E. WOODALL

ADDRESS

MAR 19 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

D 62589

REGISTERED NO.

B8 D 62589

CITY OF BALTIMORE: (No. Municipal Hospital ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James T. Cook(a) RESIDENCE. No. 33 N. Eden St. ST. \_\_\_\_\_ WARD. \_\_\_\_\_

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45

--

--

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland10 NAME OF FATHER James Cook

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER Harriet Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant Hospital Records,(Address) Municipal Hospital.

15

MAR 20 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 19 22

17

I HEREBY CERTIFY, That I attended deceased from

February 9, 19 22, to March 16, 19 22.that I last saw him alive on March 16, 19 22.and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH\* was as follows:

Syphilitic aortic insufficiency

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

3/17/22 Address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL  
Commissioner Health,

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

99



## HEALTH DEPARTMENT—CITY OF BALTIMORE

62590

## D 62590 CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 5 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Bias(a) RESIDENCE. NO. 210 Chestnut St. ST. 5 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18317 AGE Years 90 Months -- Days -- If LESS than 1 day, hrs. -- or min. --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

## 14

Informant Hospital Records, (Address) Municipal Hospital,

## 15

MAR 20 1922 ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 192217 I HEREBY CERTIFY, That I attended deceased from January 11 1921 to March 17 1922, that I last saw him alive on March 16 1922, and that death occurred, on the date stated above, at 5:00 A.M.  
The CAUSE OF DEATH\* was as follows:Chronic nephritis(duration) 5 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clayton M. Neill M. D.3/18/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

HOPKINS HOSPITAL20 UNDERTAKER Commonwealth Health,

ADDRESS

J. W. WOODALL

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62591 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

171 D 62591  
REGISTERED NO. C

1-PLACE OF DEATH  
CITY OF BALTIMORE (No. *3070* *Waspel* *3* ST. WARD)  
2-FULL NAME *William M. Cable*  
(Residence in Baltimore: No. *917* *E. Lombard* St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED *Single*  
(Write the word.)  
6-DATE OF BIRTH, *October*, *1* (Month) (Day) (Year)  
7-AGE, *59* yrs. mos. da. If LESS than 1 day, ... hrs. or ... min.?  
8-OCCUPATION:  
(a) Trade, profession, or particular kind of work *Cable*  
(b) General nature of industry, business, or establishment in which employed (or employer) *040*

9-BIRTHPLACE, (State or Country),

PARENTS.  
10-NAME OF FATHER,  
11-BIRTHPLACE OF FATHER (State or Country),  
12-MAIDEN NAME OF MOTHER  
13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

File *MAR 20 1922* *ROBERT A. KRAUTER* Registrar.

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH, *Mar 18, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

*inquest* and that said deceased came to death *on the day stated above.*

The CAUSE OF DEATH\* was as follows:

*Suicide by cutting*  
*throat with razor*  
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Arthur J. Carter* M. D.

(Coroner)  
*3-17-22* (Address) *1111*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the  
of death.... yrs. .... mos. .... ds. State.... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

*HOPKINS HOSPITAL*

*MAR 20 1922*

20-UNDERTAKER

ADDRESS

*Commissioner of Health*

THE MORQUE.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62592

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 631 W. Redwood

ST.: WARD)

2-FULL NAME *Malcolm White*

(a) RESIDENCE. NO. 631 W. Redwood

ST.,

WARD. *Green*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Married*

5a If married, widowed, or divorced

HUSBAND of

*May White*6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*35*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Black Smith*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Unknown*

10 NAME OF FATHER

*Unknown*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Unknown*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Unknown*

14

Informant (Address)

*Mr. Barker 631 W. Redwood St.*

15

FILE

MAR 2 0 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 15* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

*March 13*, 19 *22*, to *March 15*, 19 *22*.that I last saw him alive on *March 15*, 19 *22*.and that death occurred, on the date stated above, at *10:15 P* m.

The CAUSE OF DEATH\* was as follows:

*Myocardial Infarction*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Chronic Nephritis*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physical signs*(Signed) *T. B. Brown*, M. D.-15, 1922 Address *515 Columbia Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Palomares Cemetery**Mar 21 1922*

20 UNDERTAKER

*John J. Brown*

ADDRESS

*101 S. Howard St.**101 S. Howard St.*

nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Currie  
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62593

## CERTIFICATE OF DEATH.

D 62593

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 McHenry St. 21 WARD)

## 2-FULL NAME

(a) RESIDENCE. No. 911 McHenry St.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 29 1921

7 AGE

Years

Months

Days

10 LESS than 1 day, hrs. or min.

6

20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

OOD

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

John Emrick

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Mary Elizabeth Palmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Mr. John Emrick  
911 McHenry St.

15

Filed

MAR 20 1922

ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/19/22 19

17

I HEREBY CERTIFY, That I attended deceased from

3/14/22, to 3/19/22, 19

that I last saw her alive on 3/18/22, 19

and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH\* was as follows:

Acute enteritis  
melic, dtae pneumonia

(duration) yrs. 4 mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? 40

What test confirmed diagnosis? blood

(Signed) Bernard J. Lang M. D.

Res. 1922 (Address) 910 McHenry St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cem.

Mar 21 1922

20 UNDERTAKER

John J. Cowan

ADDRESS

901 Haller St.



D 62594 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62594

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2104 Homewood Ave. ST.; WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 2104 Homewood Ave. St. 13 yrs., mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE.

White

## 5-SINGLE,

MARRIED, Widowed,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH.

Jan 19, 1889

(Month)

(Day)

(Year)

## 7-AGE.

83

yrs.

mos.

da.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular

kind of work None

(b) General nature of industry, business, or establishment in which

employed (or employer) 000

9-BIRTHPLACE,  
(State or Country),

Balto

## 10-NAME OF FATHER,

Richard Woods

11-BIRTHPLACE OF FATHER  
(State or Country),

Balto

## 12-MAIDEN NAME OF MOTHER

Ann Gallagher

13-BIRTHPLACE OF MOTHER  
(State or Country),

Penn.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Shriver

(Address) 2104 Homewood Ave.

## 15-

Robert P. Harrison,

Burial Permit Clerk Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

March 18, 1922

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

1916, to March 18, 1922,

that I saw her alive on March 18, 1922,

and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH\* was as follows:

Cerebrae Embolism

(Duration) yrs. mos. da. 5

CONTRIBUTORY (Secondary) Arteriosclerosis +

(Duration) yrs. mos. da. Chronic myocarditis

(Signed) Geo. M. Leau M. D.

March 20, 1922 (Address) 20 E. Pratt St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

London Park March 21, 1922

## 20-UNDERTAKER

C. A. Wiedefeld 501 E 22

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AR 201922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62595

D 62595

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 73 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

10 LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

Burial Permit Clerk Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-I HEREBY CERTIFY, That I attended deceased from

3/1 1907, to 3/18 1922,

that I saw her alive on 3/18 1922,

and that death occurred, on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH\* was as follows:

Nephritis with much heart compensation  
(Duration) 15 yrs. 1 mos. 1 da.

CONTRIBUTORY (Secondary)

(Duration) 10 yrs. 10 mos. 1 da.

(Signed) H. Stanley G. M.D.

3/20/22 (Address) 1200 S. E. 1st St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 62596

D 62596

## CERTIFICATE OF DEATH. X 90

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1802 Lexington ST., 70 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 3 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1848

7 AGE Years 74 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant (Address)

## 15

Filed Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1922, to Mar 19, 1922,

that I last saw her alive on Mar 19, 1922,

and that death occurred, on the date stated above, at 11:45 P. M.

The CAUSE OF DEATH\* was as follows:

Coronary valvular (all valves) insufficiency

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Kind Island

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. E. Knapp, M. D.

(Address) 1002 P. Lane

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Stevensville Md.

20 UNDERTAKER

E &amp; B Harle 115 E West St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

20 1922

Burial Permit Clerk

D 62597 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62597

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 W. Lombard St. ST. 19 WARD)

## 2-FULL NAME

Johanna Thirion

## (a) RESIDENCE NO.

1310 W. Lombard St.

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds.

(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Peter Thirion

6 DATE OF BIRTH (month, day, and year) Mch. 15 1850

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
72 0 3

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lansdowne Md.  
(State or country)

10 NAME OF FATHER Michael Tierney

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER Mary Ford

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

## 14

Informant Peter Thirion  
(Address) 1310 W. Lombard St.

## 15

Robert P. Harrison

, 19

Burial Permit clerk

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 18 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 1, 1920, to Mch. 18, 1922,  
that I last saw him alive on Mch. 17, 1922,

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH\* was as follows:

Chronic - interstitial  
Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? 30 Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

Mch. 18, 1922 (Address) 352 - Mch. 18, 1922

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cathedral

DATE OF BURIAL

Mch. 21 1922

20 UNDERTAKER

J. B. Cook

ADDRESS

1003 1/2 B. Alameda

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R2 01922



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62598

## CERTIFICATE OF DEATH.

D 62598

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *South Balto Gen. Hospital* ST. *70* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*James McConville*

## (a) RESIDENCE. NO.

*2550 W. Fayette St.* ST.

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

*15* yrs.*8* mos.*24* ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed,

or Divorced (write the word)

*Single*

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*June 24 1906*

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*15**8**24*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Musician*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

*Baltimore*

(State or country)

*Maryland.*

## 10 NAME OF FATHER

*George B. McConville*

## 11 BIRTHPLACE OF FATHER (city or town)

*Balto.*

(State or country)

*Maryland*

## 12 MAIDEN NAME OF MOTHER

*Carrie E. Nickles*

## 13 BIRTHPLACE OF MOTHER (city or town)

*Baltimore*

(State or country)

*Maryland.*

## 14

Informant

*Mrs. Carrie E. McConville*

(Address)

*2550 West Fayette St.*

AR 2-0-1922

*Robert E. Harrison*

Burial Permit Clerk

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 20 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from  
*March 8 1922*, to *March 20 1922*,  
that I last saw him alive on *March 20 1922*,  
and that death occurred, on the date stated above, at *2:50 A* m.

The CAUSE OF DEATH\* was as follows:

*Ruptured gangrenous Appendicitis*CONTRIBUTORY  
(Secondary)*Intestinal Obstruction*  
(duration) yrs. mos. *10* ds.(duration) yrs. mos. *5* ds.

## 18 Where was disease contracted

if not at place of death?

*at home*

Did an operation precede death?

*yes*Date of *3/8/22*

Was there an autopsy?

*no*

What test confirmed diagnosis?

*Operation.*

(Signed)

*Joseph Pokorny*

M. D.

*3/20/22 (Address) South Balto. Gen. Hospital*\*State the Disease Causing Death, or in Deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Loudon Park Cemetery?**3/22 1922*

## 20 UNDERTAKER

## ADDRESS

*Joe B. Cook**1003 W. Balto.*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62599

## CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *7th. Gen. Hosp* ST. *7* WARD)

2-FULL NAME

(Residence in Baltimore: No. *611 N. Bond St*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

IT LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Hartigan,

101

Registrar.

Burial Permit Clerk

### CORNER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Severely regulated Acute Myocardial Infarction*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.

(Coroner.)

March 20, 1922 (Address) 2802 Channing St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

611 N. Bond St.

Former or usual residence same

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore Gen. March 22, 1922

20-UNDERTAKER

ADDRESS

J. Sander Soas 1710 Bond St

3201922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62600

## CERTIFICATE OF DEATH.

D 62600

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 E. Twentieth

ST.:

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Kane

(a) RESIDENCE. No. Texas, Balto. Co., Md.

ST.:

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 4 mos. 11 ds. How long in U. S., if of foreign birth? 50 yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John Kane

6 DATE OF BIRTH (month, day, and year) Aug. 15, 1849

7 AGE

Years

Months

Days

If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.

72

7

3

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER Bernard McDermott

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER Mary Garrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant Miss Mary C. Kane (Address) Texas, Balto. Co., Md

15

AR 2 0 1922

19 Robert F. Harrison

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18, 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan., 1922, to March 18, 1922, that I last saw him alive on March 18, 1922, and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH\* was as follows:

Cancer of Stomach

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

CONTRIBUTORY (Secondary)

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

18 Where was disease contracted if not at place of death? Texas - Balto Co.

Did an operation precede death? No Date of \_\_\_\_

Was there an autopsy? No

What test confirmed diagnosis? Smear, histology, bacteriology (Signed) Charles O'Donovan, M. D.

4219, 1922 (Address) St. E. Road 11

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Joseph's Cemetery, Texas, 3/21, 1922

20 UNDERTAKER

ADDRESS

Henry W. Mears &amp; Son 805 N. Calvert

D 62601

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH US. Veterans' Hosp. #56  
Fort McHenry Md.  
CITY OF BALTIMORE: (No. ST., WARD)

REGISTERED NO. ....  
(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

2. FULL NAME Stephen Wright.  
US. Veterans' Hosp. #56 Fort McHenry Md.

(a) RESIDENCE NO. .... ST., WARD ....  
(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored. 5 Single, Married, Widowed,  
or Divorced, (write the word) Married.

5a If married, widowed, or divorced  
HUSBAND of unknown  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years Months Days If LESS than  
39 yrs. -- -- 1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED Cook. 021  
(a) Trade, profession or  
particular kind of work

(b) General nature of industry,  
business, or establishment in  
which employed (or employer) -----

(c) Name of employer -----

9 BIRTHPLACE (city or town) Maryland.  
(State or country)

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown  
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown  
(State or country)

14 Informant E. T. Rosenbrack Registrar  
(Address) US. V. Hosp. #56

15 Robert P. Harrison,  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18, 1922

17 I HEREBY CERTIFY, That I attended deceased from  
Nov. 1, 1920 to March 18, 1922.  
that I last saw him alive on March 18, 1922,  
and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH\* was as follows:

Potts disease lumbar spine,  
T.B. cystitis, Hemiplegia old  
left.

--- (duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

--- (duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

Clinic report.

What test confirmed diagnosis?

(Signed) J. N. Gordon, M. D.  
3/21/22 (Address) US. V. Hosp. #56 Balt. Md.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Sandy Hill Md.

20 UNDERTAKER

S. Lunsford & Bro

DATE OF BURIAL

3/20, 22

ADDRESS 1127

E. Balt. Md.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state  
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-  
TION is very important. See instructions on back of certificates.

R2 01922



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62602

## CERTIFICATE OF DEATH.

D 62602

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *815 S. Fourth*ST. *26* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Sophia Stratmeyer*

## (a) RESIDENCE NO.

*815 S. Fourth*

ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *47* yrs. *1* mos. *3* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Divorced*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Feb. 15-1875*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*47**1**3*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Baltimore, Md.*

## 10 NAME OF FATHER

*Frank McNew*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Baltimore, Md.*

## 12 MAIDEN NAME OF MOTHER

*Mary Frenwald*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Baltimore, Md.*

## 14

Informant

(Address)

*Mamie Hennigan**815 S. Fourth St.*

## 15

*Robert P. Hart*

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*March 18 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*March 4, 1922, to March 18, 1922.*that I last saw him alive on *March 18, 1922.*and that death occurred, on the date stated above, at *6 P.* m.

The CAUSE OF DEATH\* was as follows:

*Simple bacterial meningitis*(duration) yrs. mos. *16* ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date of \_\_\_\_\_Was there an autopsy? *No*What test confirmed diagnosis? *None*

(Signed)

*David W. Jones*

M. D.

3/20/1922 Address

*1013 S. Ellwood Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

*Oaklawn*

## DATE OF BURIAL

*March 21 1922*

## 20 UNDERTAKER

*Jerklen & Jerklen*

## ADDRESS

*1739 Eager*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2 01922

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62603

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 9301 Homestead ST. 9 WARD)

2. FULL NAME Dorothea E. Williams

(a) RESIDENCE No. 9301 Homestead ST. WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 7 1921

7 AGE Years 4 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) C. Williams 9301 Homestead St.

15 Robert P. Barry, Jr. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1922

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1922, to March 19, 1922.

that I last saw her alive on March 19, 1922, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam.

(Signed) B. V. Kelly, M. D.

19 22 (Address) 3522 Old York Road

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE- DATE OF BURIAL

19 22

19 22

19 22

19 22

19 22

19 22

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62604

D 62604

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *624 S. Linwood* ST., *1* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. *624 S. Linwood* ST., *1* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Female*COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of *William Jay*6 DATE OF BIRTH (month, day, and year) *Sept 13 1864*

7 AGE

Years *57*Months *6*

Days

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at Home*(b) General nature of industry, business, or establishment in which employed (or employer) *odd*

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto Md*  
(State or country)10 NAME OF FATHER *Geo Bowers*11 BIRTHPLACE OF FATHER (city or town) *Bellport City*  
(State or country)12 MAIDEN NAME OF MOTHER *Esther Zapp*13 BIRTHPLACE OF MOTHER (city or town) *Balto Md*  
(State or country)

14

Informant *Geo A - Bowers*(Address) *1930 Hanover*

15

Robert P. Registrar

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 19 22*17 I HEREBY CERTIFY, That I attended deceased from *Mar 19 22*that I last saw *her* alive on *Mar 18 19*and that death occurred, on the date stated above, at *540 p* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Infective Hepatitis*

CONTRIBUTORY (Secondary)

(duration) yrs. *6* mos. ds.(duration) yrs. *5* mos. ds.18 Where was disease contracted if not at place of death? *from travel*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *clinical and lab*(Signed) *Wm H. Ingle*, M. D.

, 19

(Address) *2958 E Balto*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER *Wm Cook*

ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R2 01922

INFORMATION.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 62605

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62605

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Howard A. Kelly Hospital, etc*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. *1418 Eutan Place* ST.: *14* WARD)

2-FULL NAME *William P. Sandwich*

(a) RESIDENCE. NO. *Montgomery Ala.* ST.,

WARD *Montgomery, Ala.*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

*10* ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Kellis Sandwich*

6 DATE OF BIRTH (month, day, and year) *April 18 1878*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*47*

*11*

*2*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Produce merchant*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Alabama*

10 NAME OF FATHER

*J. T. Sandwich*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Alabama*

12 MAIDEN NAME OF MOTHER

*unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*unknown*

14

Informant

(Address)

*Kellis Sandwich*

*816 S. Court St. Montgomery Ala.*

15

Filed

19

*Robert P. Harrison*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 20 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Oct 14*, 1921, to *March 20*, 1922,

that I last saw him alive on *March 20*, 1922,

and that death occurred, on the date stated above, at *10:05 am.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of rectum*

CONTRIBUTORY (Secondary)

(duration) yrs. *5+* mos. ds.

(duration) yrs. *4+* mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *Yes* Date of *March 18, 1922*

Was there an autopsy? *No*

What test confirmed diagnosis? *Microscopic examination*

(Signed) *Dudley A. Roberts*, M. D.

*March 20 1922* (Address) *1418 Eutan Place*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Chas. G. Black 742 W. North*

MAR 20 1922

Burial Permit Clerk,



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62606

D 62606

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *13 N. Collington Ave.* ST., *6* WARD)

## 2. FULL NAME

*Thomas J. Hennessy*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *13 N. Collington Ave.* ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Elizabeth Hennessy*6 DATE OF BIRTH (month, day, and year) *— 1853*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *69*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Ireland*10 NAME OF FATHER *Michael Hennessy*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ireland*12 MAIDEN NAME OF MOTHER *Ellen Furlong*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*14 Informant (Address) *Mrs Elizabeth Hennessy  
13 N. Collington Ave.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 18* 19 *22*

17

I HEREBY CERTIFY, that I attended deceased from

*Feb 9, 1922, to March 18, 1922.*that I last saw him alive on *Mar 17*, 19 *22*,and that death occurred, on the date stated above, at *10* m.

The CAUSE OF DEATH was as follows:

*Diabetes Mellitus*(duration) *1* yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Diabetes Coma*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Urinalysis etc*(Signed) *Geo. J. Meyer* M. D., 19 (Address) *6 N. J. Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*New Cathedral**3/21 1922*

20 UNDERTAKER

ADDRESS

*John A. Moran 3000 E. Balto St.*

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R2 07922

19

Registrar

D 62607

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62607

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2034 E. Fairmount Ave. ST. 6 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Wagner(a) RESIDENCE. No. 2034 E. Fairmount Ave. ST. 6 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mattie B. Wagner6 DATE OF BIRTH (month, day, and year) Feb. 17-18567 AGE Years 66 Months 2 Days 2 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Vice President

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 2nd National Bank9 BIRTHPLACE (city or town) Balto. City (State or country) Md.10 NAME OF FATHER John Wagner11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)14 Informant Mattie B. Wagner (Address) 2034 E. Fairmount Ave.15 Robert P. Harrison Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19 192217 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1922, to Mar 18, 1922, that I last saw him alive on March 12, 1922, and that death occurred, on the date stated above, at 6:30 P. M. The CAUSE OF DEATH\* was as follows:Apoplexy  
(Sudden)  
(duration) — yrs. 0 mos. 23 hrs.CONTRIBUTORY (Secondary) Arteriosclerosis (duration) — yrs. 1 mo. 18 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of +Was there an autopsy? NoWhat test confirmed diagnosis? Clinical & Chemical(Signed) Charles E. Hill M. D.19 (Address) Wylie St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Luclid Ridge Cem. Feb. 21 1922

20 UNDERTAKER ADDRESS

Wm. C. Black 927 N. Broadway

Physicians should state EXACTLY. Exact statement of OCCASION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

AR 2 01922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62608

## CERTIFICATE OF DEATH.

161-001  
D 62608  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1710 Poplar Grove. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. Lifetime 1710 Poplar Grove St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE

White

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Child

## 6-DATE OF BIRTH

Mar

19

1922

(Month)

(Day)

(Year)

## 7-AGE

If LESS than 1 day,

12 hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9-BIRTHPLACE

(State or Country)

Baltimore Md.

## 10-NAME OF FATHER

J. Malcolm MacDermott

## 11-BIRTHPLACE OF FATHER (State or Country)

Darby Penna.

## 12-MAIDEN NAME OF MOTHER

Leafy C. Groswell

## 13-BIRTHPLACE OF MOTHER (State or Country)

Lummount Md.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

Robert P. Harrison,

Filed, 191

Registrar.

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

Mch

20

1922

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Mch 19 1922, to Mch 20 1922

that I saw her alive on Mch 19 1922

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH\* was as follows:

Insufficient Anesthesis  
(Duration) yrs. mos. ds. Lifetime

## CONTRIBUTORY (Secondary)

Premature birth

(Duration) yrs. mos. ds.

(Signed) George Shannon M. D.

3/21/22, 1922 (Address) 700 Fulton Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Western Cemetery

March 20 1922

## 20-UNDERTAKER

## ADDRESS

Robert S. Lillo

212 E. Lombard

AR 2 01922

D 62609

## HEALTH DEPARTMENT—CITY OF BALTIMORE, 001

## CERTIFICATE OF DEATH.

161 D 62609  
REGISTERED NO. C.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 Poplar Grove ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and SU out No. 18.)

## 2-FULL NAME

20 Twin of Three, Malcolm and Leafy H. Dermott

(Residence in Baltimore: No. 1710 Poplar Grove St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE,

White

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Child

## 6-DATE OF BIRTH,

Mch

19

1922

(Month)

(Day)

(Year)

## 7-AGE,

If LESS than 1 day,

7 hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Child - 000

## 9-BIRTHPLACE,

(State or Country),

Baltimore Md.

## 10-NAME OF FATHER,

J. Malcolm Mac Dermott

## 11-BIRTHPLACE OF FATHER

(State or Country),

Darby Penna

## 12-MAIDEN NAME OF MOTHER

Leafy C. Crosswell

## 13-BIRTHPLACE OF MOTHER

(State or Country),

Fairmount Md.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

Filed.....Robert M. Harrison.....

Registrar.

201922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Mar.

20

1922

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Mch 19 1922, to Mar. 20 1922

that I saw her alive on March 19 1922

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH\* was as follows:

Insufficient Circulation

(Duration) yrs. mos. ds.

Premature Birth

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) George C. Shannon M. D.

3/20, 1922 (Address) 700 Fulton Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20-UNDERTAKER ADDRESS

Hester Lem 2750 Edmondson



state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62610

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62610

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *416 S. Wolfe* St. *7* Ward)

2-FULL NAME

(Residence in Baltimore: No. *416 S. Wolfe* St.; yrs. .... mos. .... ds.)

Registered No. C. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *white* 5-Single, *single* Married, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH, *Jan 1* 1922 (Month) (Day) (Year)

7-AGE, *2* yrs. *18* mos. *18* ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *none* (b) General nature of industry, business, or establishment in which employed (or employer). *ood*

9-BIRTHPLACE, (State or Country), *Baltimore*

10-NAME OF FATHER, *Frank Foster*

11-BIRTHPLACE OF FATHER, (State or Country), *Baltimore*

12-MAIDEN NAME OF MOTHER, *Teresa Kabat*

13-BIRTHPLACE OF MOTHER, (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Joseph Kabat* (Address) *416 S. Wolfe*

15- *Robert P. Harrison,* Registrar.

*Mar 20 1922* Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Mar 19* 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, hereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above. The CAUSE OF DEATH was as follows: *Gastro Enteritis*

CONTRIBUTOR (Secondary) *Cholera* (Signed) *C. O. Oates* M. D. (Coroner) (Address) *Mar 19 1922*

State the Disease Causing Death, or, in deaths from Violent Causes, State (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, .... yrs. .... mos. .... ds. In the State, .... yrs. .... mos. .... ds. Where was disease contracted, if not at place of death? ....

Former or usual residence, ....

19-PLACE OF BURIAL OR REMOVAL, *Hob. Razary* DATE OF BURIAL, *March 21, 1922* 20-EMERALD, *John A. Miley* ADDRESS, *1803 Bank*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

D 62611

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62611

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Joseph Hospital* ST. *V* WARD)

2-FULL NAME

(Residence in Baltimore: No. *422 S. Register* St.; yrs.. mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE,

*White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

*Married*

6-DATE OF BIRTH,

*March 16, 1880*  
(Month) (Day) (Year)

7-AGE,

*42* yrs. *2* mos. *2* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

*Labor 074*  
*Meridore*

9-BIRTHPLACE.

(State or Country).

*Poland*

10-NAME OF FATHER,

*Stanislaus Szymanowski*

11-BIRTHPLACE OF FATHER

(State or Country).

*Poland*

12-MAIDEN NAME OF MOTHER

*Eva Mahulewicz*

13-BIRTHPLACE OF MOTHER

(State or Country).

*Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Mrs. Josephine Szymanowski*

(Address)

*422 S. Register*

15-

MAR 20 1922

Robert P. Harrison,

191

Burial Permit Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Mar 19, 1922*  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held as *Coroner*  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest*  
(Inquest, au-

*Inquest* find that said deceased came to death  
topsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

*poisoning, fell down*  
*hole in boat.*

(Duration).... yrs. .... mos. .... ds.

CONTRIBUTORY  
(Secondary)

(Duration).... yrs. .... mos. .... ds.

(Signed) *John M. Weber* M. D.

(Coroner)

3-29-1922 (Address) *1803 Bank*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) *Means of Injury* and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. .... mos. .... ds. In the State.... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*Gaby Rosary* *March 24, 1922*

20-UNDERTAKER ADDRESS

*John M. Weber* *1803 Bank*

D 62612

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62612

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen. Hospital ST. V WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Ignatz Kowalik

## (a) RESIDENCE. NO.

527 S. Chapel St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

10 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of

Catherine Kowalik

(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

May 4 1880

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

311014

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Poland

## 10 NAME OF FATHER

Jahub Kowalik

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

## 12 MAIDEN NAME OF MOTHER

unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

## 14

Informant (Address)

Mrs. Catherine Kowalik  
527 S. Chapel St.

## 15

MAR 20 1922

Burial Permit Clerk

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1922

17

I HEREBY CERTIFY, That I attended deceased from March 16 1922, to March 18 1922that I last saw him alive on March 18 1922and that death occurred, on the date stated above, at 7:40 A. m.

The CAUSE OF DEATH\* was as follows:

Car buncle of upper lip

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds. 7

(duration)

yrs.

mos.

ds. 2

## 18 Where was disease contracted if not at place of death?

at home

Did an operation precede death?

yes

Date of

March 16, 1922

Was there an autopsy?

no

What test confirmed diagnosis?

no

(Signed)

Joseph Pokorny

M. D.

19 (Address)

South Balto Gen. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

John MontebelloMarch 22 1922

## 20 UNDERTAKER

## ADDRESS

John Montebello1803 Bank St.

PHYSICIANS should be stated EXACTLY. Exact statement of OCCASION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 62613

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62613

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2102 Cambridge ST.: 1 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

John Perc

## (a) RESIDENCE. NO.

2102 Cambridge ST.

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofCatherine Perc

## 6 DATE OF BIRTH (month, day, and year)

1866

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.52 14 14 14

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Poland

## 10 NAME OF FATHER

unknown11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Poland

## 12 MAIDEN NAME OF MOTHER

unknown13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Poland

## 14

Informant  
(Address)John Perc  
2102 Cambridge

## 15

Filed

Robert E. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

March 13, 1922, to March 18, 1922.that I last saw him alive on March 18, 1922.and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH\* was as follows:

John Perc

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? Yes Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Diagnosis

(Signed)

W. A. Harrison

M. D.

3/17/1922 (Address) 1622 E. 17th St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Holy RosaryMarch 24 1922

## 20 UNDERTAKER

## ADDRESS

John Mawcher 1803 Bank

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AR 3 0 1922

Burial Permit Clerk



D 62614

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH. D 62614

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.: *V* WARD)

## 2-FULL NAME

*Catherine Hantz*

## (a) RESIDENCE. No.

*523 S. Ann*

(Usual place of abode)

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *15* yrs. mos. ds.

Gs. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Single*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Sept 1905*

## 7 AGE

*17*

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

*Cann Shop worker*

## (b) General nature of industry, business, or establishment in which employed (or employer)

*Manufacture of Cans*

## (c) Name of employer

*Metal Package Co. (Bryle Road)*

## 9 BIRTHPLACE (city or town) (State or country)

*Bohemia*

## 10 NAME OF FATHER

*Michael Hantz*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Poland*

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

## Informant (Address)

*Michael Hantz  
523 S. Ann*

## 15

## File

*01322*

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 19 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from  
*March 14*, 1922, to *Mar. 19*, 1922.that I last saw him alive on *Mar. 14*, 1922.and that death occurred, on the date stated above, at *10.30 P. m.*

The CAUSE OF DEATH\* was as follows:

*Myocardial Insufficiency*

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

*Benzol Poisoning-Anaemia*

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

*Metal Package Co.*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Examination*(Signed) *J. J. Jones*, M. D.3/20 1922 (Address) *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Holy Rosary March 23 1922*

## 20 UNDERTAKER

ADDRESS

*John M. Weber 1803 Bank*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY. be stated EXACTLY. AGE should be stated EXACTLY.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62615

## CERTIFICATE OF DEATH.

D 62615

1-PLACE OF DEATH

City of BALTIMORE

St. 1 Ward

Registered No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos., ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 4-COLOR OR RACE, 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, 7-AGE, 8-OCCUPATION:

(a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), 10-NAME OF FATHER, 11-BIRTHPLACE OF FATHER, (State or Country), 12-MAIDEN NAME OF MOTHER, 13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant), (Address).

15-ROBERT R. KRAUTER, Burial Permit Clerk.

16-DATE OF DEATH, 17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above. The CAUSE OF DEATH was as follows:

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, In the State, Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, 20-UNDERTAKER, ADDRESS.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above. The CAUSE OF DEATH was as follows:

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, In the State, Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, 20-UNDERTAKER, ADDRESS.

16-DATE OF DEATH, 17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above. The CAUSE OF DEATH was as follows:

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, In the State, Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, 20-UNDERTAKER, ADDRESS.

16-DATE OF DEATH, 17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above. The CAUSE OF DEATH was as follows:

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, In the State, Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, 20-UNDERTAKER, ADDRESS.

16-DATE OF DEATH, 17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above. The CAUSE OF DEATH was as follows:

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, In the State, Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, 20-UNDERTAKER, ADDRESS.

## HEALTH DEPARTMENT—CITY OF BALTIMORE 001

D 62616

## CERTIFICATE OF DEATH.

74 D 62616

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2106 AIKEN ST. ST.; 9 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MARIE LINGELBACH(a) RESIDENCE. No. 2106 AIKEN ST ST., 9 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 5 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX FEMALE 4 COLOR OR RACE WHITE 5 Single, Married, Widowed, or Divorced (write the word) WIDOWED

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. - 18627 AGE Years 59 Months 5 Days 0 If LESS than 1 day, hrs. 0 or min. 0

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work AT HOME

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) BALTIMORE, MD.10 NAME OF FATHER FREDERICK SCHNEIDER11 BIRTHPLACE OF FATHER (city or town) (State or country) GERMANY12 MAIDEN NAME OF MOTHER SOPHIE LEFFERT13 BIRTHPLACE OF MOTHER (city or town) (State or country) GERMANY14 Informant GEORGE GEIWITS (Address) 2106 AIKEN ST.15 Filed MAR 21 1922 19 ROBERT R. KRAUTER Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 20 192217 I HEREBY CERTIFY, That I attended deceased from Mar 17, 1922, to Mar 20, 1922that I last saw him alive on Mar 21, 1922,and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage(duration) yrs. mos. 4 ds.CONTRIBUTORY arterio-sclerosis (Secondary)(duration) 1 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Richard C. Schuler, M. D.19 Mar 20 (Address) 514 E Baltimore

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Oak Lawn Cemetery Mar 2320 UNDERTAKER ADDRESS 22Louis Heemann 328 Brow

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62617

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Asylum - Orleans St.*  
CITY OF BALTIMORE (No. *School # 40*) ST. *6* WARD  
2-FULL NAME *Isador Kantar*  
(Residence in Baltimore: No. *105 N. Bond*)

90 D 62617  
REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*  
(Write the word.)

6-DATE OF BIRTH, *1*  
(Month) (Day) (Year)

7-AGE, *14* yrs. mos. ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *School-boy*  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Russia*

10-NAME OF FATHER, *Leon Kantar*

11-BIRTHPLACE OF FATHER (State or Country), *Russia*

12-MAIDEN NAME OF MOTHER *Mary Winstock*

13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Leon Kantar*

(Address) *105 N. Bond St.*

15-

MAR 21 1922 101... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Mar 20, 1912*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest*  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*  
(Inquest, au-

*opsy* find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Acute Heart Disease*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *John J. ...* M. D.

(Coroner)

3-20-22 (Address) *...*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, DATE OF BURIAL,

*Bellevue Hospital* *Mar 21, 1912*

20-UNDERTAKER ADDRESS

*Jack Lewis* *1429 E. Baltimore*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62618

## CERTIFICATE OF DEATH.

57 D 62618

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST.

WARD) 17

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

William Sharpman

## (a) RESIDENCE NO.

803 Edmondson Ave.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Unknown

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

male

## 4 COLOR OR RACE

white

## 5 Single, Married, Widowed, or Divorced, (write the word)

single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Unknown

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

26

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Russia

## 10 NAME OF FATHER

Abraham Sharpman

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

## 12 MAIDEN NAME OF MOTHER

Ida Chaen

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

## 14

Informant (Address)

JOHNS HOPKINS HOSPITAL

ROBERT R. KRAUTER,

Burial Permit Clerk

## 15

MAR 21 1922

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 19<sup>th</sup> 1922

## 17

I HEREBY CERTIFY, That I attended deceased from March 19<sup>th</sup> 1922 to March 14<sup>th</sup> 1922,that I last saw him alive on March 19<sup>th</sup> 1922,

and that death occurred, on the date stated above, at 9:30 p. m.

The CAUSE OF DEATH\* was as follows:

Diabetic acidosis and coma

(duration) yrs. mos. 2 ds.

## CONTRIBUTORY

(Secondary)

(duration) 2 yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

Home

## Did an operation precede death?

No

Date of

## Was there an autopsy?

No

## What test confirmed diagnosis?

Blood chemistry

(Signed) Francis R. Diemide, M. D.

Mar. 20, 1922 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Bellevue Road

## 20 UNDERTAKER

John H. Hays

## DATE OF BURIAL

3-21-22

## ADDRESS

4392 Baco

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 62619

HEALTH DEPARTMENT—CITY OF BALTIMORE 62619

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *8* ST.; *90* WARD)

## 2-FULL NAME

(a) RESIDENCE. No. *1511 East Federal* ST. *8* WARD. *90*

(Usual place of abode)

Length of residence in city or town where death occurred *life* yrs. *0* mos. *0* ds.How long in U. S., if of foreign birth? yrs. *0* mos. *0* ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Married*5a If married, widowed, or divorced, HUSBAND of (or) WIFE of *Mr. John Stenger*6 DATE OF BIRTH (month, day, and year) *Jan. 11, 1873*

7 AGE

Years *49*Months *2*Days *9*If LESS than 1 day, hrs. *0* or min. *0*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*(b) General nature of industry, business, or establishment in which employed (or employer) *037*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balti Md.*10 NAME OF FATHER *?*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Austria*12 MAIDEN NAME OF MOTHER *?*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Austria*

14

Informant (Address) *Mercy Hospital Record*

15

Filed *MAR 21 1922* ROBERT R. KRAUTER, *Deputy Permit Clerk*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 20, 22*

17

I HEREBY CERTIFY That I attended deceased from *March 17, 22* to *March 20, 22*that I last saw her alive on *March 20, 22*and that death occurred, on the date stated above, at *8:05 A. M.*

The CAUSE OF DEATH\* was as follows:

*Myocarditis with Arricular*

CONTRIBUTORY

*Hypertensive* (duration) yrs. *14* mos. *0* ds.18 Where was disease contracted *Home* If not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical Signs & Symptoms*(Signed) *John J. G. M. D.*19 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Green Mount Cem**March 23 1922*

20 UNDERTAKER

ADDRESS

*William Cook**502 E North*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62620

## CERTIFICATE OF DEATH.

90 D 62620

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1524 Holbach St. 9 WARD)

## 2. FULL NAME

(a) RESIDENCE No. 1524 Holbach ST., WARD (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth 10 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of Richard F. Frazier

6 DATE OF BIRTH (month, day, and year) April 10 1853

7 AGE Years 68 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Portsmouth

10 NAME OF FATHER John C. Donnelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Ann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

## PARENTS

14 Informant (Address) Joseph F. Frazier 1524 Holbach St.

## 15

MAR 21 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1922

17 I HEREBY CERTIFY, That I attended deceased from

March 16, 1922, to March 20, 1922,

that I last saw her alive on March 20, 1922,

and that death occurred, on the date stated above, at 1:15 a.m.

The CAUSE OF DEATH\* was as follows:

Mitral regurgitation

(duration) yrs. 3 mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. F. Frazier, M. D.

31, 1922 (Address) 1206 E. Preston

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Cross Church, Baltimore, Md. 1922

FUNERAL

ADDRESS

William C. 502 E. Pratt St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62621

D 62621

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH

Robt Garrett Hosp for Children

REGISTERED NO.

113

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

27 N Carey

ST.,

WARD)

2. FULL NAME

Vernon Selmyer

(a) RESIDENCE NO.

1605 Asquith

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

single

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Jan 4 1922

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Ind

10 NAME OF FATHER

Harry Selmyer

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Mary J Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md

14

Informant (Address)

Harry Selmyer 1605 Asquith St

15

MAR 21 1922

ROBERT R. KRAUTER,

Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 20 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 8 1922 to March 20 1922.

that I last saw him alive on March 20 1922,

and that death occurred, on the date stated above, at 4<sup>40</sup> P. M.

The CAUSE OF DEATH\* was as follows:

Intestinal Indigestion

(duration) yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 12 mos. 12 ds.

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death? no Date of

Was there an autopsy?

yes

What test confirmed diagnosis?

findings

(Signed)

3/20, 1922 (Address)

27 N Carey St

M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cmn

Mch 22 1922

20 UNDERTAKER

ADDRESS

J. M. Cook

502 E North St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



D 62622

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62622

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Just E. East Charles* ST. *17* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *Abner Hugh Pellott* *Cambridge Apts. 17th St. 134* St.; yrs., mos. ds.)

## REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Male*

## 4-COLOR OR RACE

*White*

## 5-STATUS

*Married*  
~~WIDOWED~~  
~~OR DIVORCED~~  
(Write the word.)

## 6-DATE OF BIRTH

*January 1st, 1871*  
(Month) (Day) (Year)

## 7-AGE

*51* yrs. *2* mos. *18* ds.

## If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*Attorney*9-BIRTHPLACE  
(State or Country)*Towson - Balto. Md.*

## 10-NAME OF FATHER

*John S. Yellott*11-BIRTHPLACE OF FATHER  
(State or Country)*Balto. Co. Md.*

## 12-MAIDEN NAME OF MOTHER

*Mary V. Traill*13-BIRTHPLACE OF MOTHER  
(State or Country)*Fred's Md.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. C. L. Grason*(Address) *Towson Md.*

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*March 19, 1922*  
(Month) (Day) (Year)

## 17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Thrombosis of the coronary arteries  
of the heart  
resulting in a sudden death  
CONTRIBUTORY is atherosclerosis of the coronary arteries  
(Secondary) plaque on the wall of the coronary arteries  
(Duration) yrs. mos. ds.*(Signed) *M. D.*

(Coroner.)

*March 20, 1922* (Address) *1059 Pine*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. ... mos. ... ds. State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

## Former or usual residence.....

## 19-PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Prophet Hill Towson**Mar 21, 1922*

## 20-UNDERTAKER

## ADDRESS

*Henry H. Jenkins Towson**McCulloch*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 21 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62623

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *20700* *Harford* ST. *17* WARD)

2-FULL NAME *William Cross*

(Residence in Baltimore: No. *2610* *Harford*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., *6* mos., *3* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *W* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*  
(Write the word.)

6-DATE OF BIRTH, *Dec* *12*, *1915*  
(Month) (Day) (Year)

7-AGE *6* yrs., *3* mos., *7* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *School*  
(b) General nature of industry, business, or establishment in which employed (or employer). *MD*

9-BIRTHPLACE (State or Country). *MD*

10-NAME OF FATHER. *William H. Cross*

11-BIRTHPLACE OF FATHER (State or Country). *MD*

12-MAIDEN NAME OF MOTHER. *Lydica Broecker*

13-BIRTHPLACE OF MOTHER (State or Country). *MD*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William H. Cross*

(Address) *2610 Harford*

15- *MAR 21 1922* ROBERT R. KRAUTER,

File *Burial Permit Clerk*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Mar* *19*, *1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest*  
(Inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said *inquest*  
(Inquest, au-

*inquest* find that said deceased came to *death*  
topical inquiry on the day stated above.

THE CAUSE OF DEATH\* was as follows:

*Pneumonia*  
*Long Cough*  
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Wm. H. Cross* M. D.  
(Coroner.)

*3-21-22* (Address) *at home*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*St. Marys Harford* *Mar. 22, 1922*

20-UNDERTAKER ADDRESS

*Chenoweth & Son* *Chestnut*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

Death Sample.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62624

CERTIFICATE OF DEATH.

161-001 D 62624

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 W. Biddle

ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Leah Sample

(a) RESIDENCE. No.

518 W. Biddle

ST. 17

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar, 18-1922

7 AGE

Years

Months

Days

If LESS than 1 day, 7 hrs. 215 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Chas. Sample

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Eastern, Md. Md.

12 MAIDEN NAME OF MOTHER

Flora Mae

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Eastern, Md. Md.

14

Informant (Address)

Chas. Sample 518 W. Biddle St.

15

Filed

MAR 21 1922

ROBERT R. KRAUTER,

Sanitary Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 18 1922 to Mar 18 1922.

that I last saw her alive on Mar 18 1922.

and that death occurred, on the date stated above, at 4 - P. m.

The CAUSE OF DEATH\* was as follows:

Premature birth (8 months)

(duration) 7 hours 215 min. yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. Sample M. D.

. 19 (Address) 906 N. Strickland St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 ADDRESS

St. Anthony's

Mar 21 1922

20 UNDERTAKER

Saml. Newberry

ADDRESS

Baltimore

MAISON should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62625

2. CERTIFICATE OF DEATH.

D 62625

1. PLACE OF DEATH  
CITY OF BALTIMORE: 1014 Central Ave ST. 10 WARD)  
2. FULL NAME Edna Irma Jarboe  
(a) RESIDENCE NO. 1014 Central Ave WARD  
(Usual place of abode)  
Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male	4 COLOR OR RACE White	5 Single, Married, Widowed, or Divorced, (write the word) Single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of		
6 DATE OF BIRTH (month, day, and year) March 15-1920		
7 AGE	Years 2	Months 5
8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		
9 BIRTHPLACE (city or town) (State or country) Balt		
10 NAME OF FATHER Wm D Jarboe		
11 BIRTHPLACE OF FATHER (city or town) (State or country) Emma		
12 MAIDEN NAME OF MOTHER Irma J. Wark		
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md		
14 Informant Wm D Jarboe (Address) 1014 Central Ave		
15 MAR 21 1922 ROBERT R. KRAUTER, Burial Permit Clerk.		

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1922

17 I HEREBY CERTIFY, that I attended deceased from March 14, 1922 to March 20, 1922 that I last saw him alive on March 20, 1922 and that death occurred, on the date stated above, at 9:30 A. m. The CAUSE OF DEATH\* was as follows: Murder

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) 7 yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Did an operation precede death? Date of Was there an autopsy? What test confirmed diagnosis? (Signed) Edward J. Leary, M. D. 3/20/22 (Address) 413 N Washington

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Albans Rd. MAR 22

20 UNDERTAKER W. J. Fickner ADDRESS



D 62626

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 D 62626

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Southern Hospital

ST.: 18 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Albert. Wolf.

## (a) RESIDENCE. No.

873 W. Fayette

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Widowed

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Dec 25<sup>th</sup> 1882

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

40

3 mos. 40

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore City

## 10 NAME OF FATHER

Jacob Wolf

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

New York City

## 12 MAIDEN NAME OF MOTHER

Mollie Freudenthal

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore City

## 14

Informant (Address)

Charles Wolf

## 15

MAR 21 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Mar 20 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb. 1, 1922, to Mar. 20, 1922,

that I last saw him alive on Mar. 20, 1922,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Pulmonary Tuberculosis

(duration) 4 mos. ds.

## 18 Where was disease contracted

If not at place of death?

Unknown

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

Municipal etc.

(Signed)

Robert C. Blake

M. D.

, 19

(Address) 1014 W. Fayette

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Hebrew Friendship

March 22 1922

## 20 UNDERTAKER

## ADDRESS

J. Ahrens &amp; Co

1611 Madison Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62627		HEALTH DEPARTMENT—CITY OF BALTIMORE D 62627	
PLACE OF DEATH		CERTIFICATE OF DEATH	
CITY OF BALTIMORE (No. <u>2402 Allendale Rd.</u> ST. <u>15</u> WARD)		REGISTERED No. C (if death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)	
2-FULL NAME <u>John Glenn</u>			
(Residence in Baltimore: No. <u>2402 Allendale Rd.</u> St. <u>4</u> yrs. <u>0</u> mos. <u>0</u> ds.)			
PERSONAL AND STATISTICAL PARTICULARS			
3-SEX <u>Male</u>	4-COLOR OR RACE <u>White</u>	5-SINGLE, <u>Married</u> (If write the word)	
6-DATE OF BIRTH <u>—</u> <u>—</u> <u>1897</u> (Month) (Day) (Year)			
7-AGE <u>25</u> yrs. <u>—</u> mos. <u>—</u> ds. If LESS than 1 day, <u>—</u> hrs. or <u>—</u> min.?			
8-OCCUPATION (a) Trade, profession, or particular kind of work <u>Janitor</u> (b) General nature of industry, business, or establishment which employed (or employer) <u>School Board.</u>			
9-BIRTHPLACE (State or country) <u>Ireland</u>			
PARENTS	10-NAME OF FATHER <u>John Glenn</u>		
	11-BIRTHPLACE OF FATHER (State or country) <u>Ireland.</u>		
	12-MAIDEN NAME OF MOTHER <u>Unknown.</u>		
	13-BIRTHPLACE OF MOTHER (State or country) <u>Ireland.</u>		
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Jas. W. Glenn</u> (Address) <u>2402 Allendale Rd.</u>			
15. <u>MAR 21 1922</u> ROBERT R. KRAUTER, Filed <u>—</u> , 191 <u>—</u> Burial Permit Clerk REGISTRY MAR			
MEDICAL CERTIFICATE OF DEATH			
16-DATE OF DEATH <u>March</u> <u>20</u> , 19 <u>22</u> (Month) (Day) (Year)			
17. I HEREBY CERTIFY, That I attended deceased from <u>March 19</u> , 19 <u>22</u> , to <u>March 20</u> 19 <u>22</u> . that I saw him alive on <u>March 20</u> , 19 <u>22</u> . and that death occurred, on the date stated above, at <u>7</u> a. m. The CAUSE OF DEATH* was as follows: <u>Arterio-sclerosis High Blood pressure—myocarditis</u> (Duration) <u>9</u> yrs. <u>0</u> mos. <u>0</u> ds. Contributory <u>Cerebral hemorrhage +</u> (SECONDARY) <u>paralysis</u> (Duration) <u>1</u> yrs. <u>0</u> mos. <u>1</u> ds. (Signed) <u>W. S. Rublett</u> M. D. <u>3/20/22</u> , 19 <u>22</u> (Address) <u>2220 Garrison</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. In the State <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, if not at place of death? Former or usual residence			
19-PLACE OF BURIAL OR REMOVAL <u>Cathedral bur.</u>		DATE OF BURIAL <u>March 22, 1922</u>	
20-UNDERTAKER <u>Heaton Hakey Sons</u>		ADDRESS <u>1837 W. North Ave.</u>	

D 62628 1900 Bk.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2413 Harlem Ave. ST. 16 WARD)

## 2-FULL NAME

Mattie V League

## (a) RESIDENCE

No. 2413 Harlem Ave. ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

Life

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White

married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Harold League

6 DATE OF BIRTH (month, day, and year)

1868

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

60

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

None

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

William Sharp

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Mattie Sharp

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Mrs H B Lehmeyer 2413 Harlem Ave

15

MAR 21 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 20<sup>th</sup> 1922

17

I HEREBY CERTIFY, That I attended deceased from

February 4<sup>th</sup> 1922, to March 20<sup>th</sup> 1922,that I last saw her alive on March 19<sup>th</sup> 1922,

and that death occurred, on the date stated above, at 49 m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

Uræmia

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? urinary —

(Signed) Richard F. Steelman M. D.

19 (Address) 1227 Lafayette Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cem

March 22 1922 ADDRESS

20 UNDERTAKER

Martin Lakeydon 1827 W North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19-H. P. Co.-1000 Bks.

D 62629

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62629

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2612 Starford ave ST. 9)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Wassman

(a) RESIDENCE. NO. 2612 Starford ave ST. 9  
(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of Charles G. Wassman (or) WIFE of Wife of

6 DATE OF BIRTH (month, day, and year) Feb 15-1863

7 AGE Years 59 Months 1 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md  
(State or country)

10 NAME OF FATHER Jacob Strick

11 BIRTHPLACE OF FATHER (city or town) Germany  
(State or country)

12 MAIDEN NAME OF MOTHER Katherine Strick

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md  
(State or country)

14 Informant Charles G. Wassman  
(Address) 2612 Starford Ave

15 Filed MAR 21 1922 19 ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20-1922

17 I HEREBY CERTIFY, That I attended deceased from March 20-1922 to March 20-1922 that I last saw him alive on March 20-1922 and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH\* was as follows:

Multiple Sclerosis of Brain

(duration) 2 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted at place of death  
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Multiple sclerosis

(Signed) L. L. Gentry M. D.

19 (Address) 2658 Harford Ave Balt Md

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Linden Park

March 23-1922

20 UNDERTAKER

Henry Lutz

ADDRESS 1203

N. Broadway



PHYSICIANS should state  
Exact statement of OCCUPA-  
TION is very important. See instructions on back of certificates.

Spec.-1-10-21 M&T-1500 Bks.

Ohler  
HEALTH DEPARTMENT-CITY OF BALTIMORE

D 62630

CERTIFICATE OF DEATH.

179 D 62630

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 600 Hampden Ave. ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE No. 600 Hampden Ave. ST. 13 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adelaide Ohler

6 DATE OF BIRTH (month, day, and year) Dec. 24, 1848

7 AGE Years 73 Months 2 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 15 (b) General nature of industry, business, or establishment in which employed (or employer) Retired 1 year. (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Andrew Ohler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Mary Budder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Ambrose Ohler (Address) 3454 Hickory Ave

15 MAR 21 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18, 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 5, 1922, to Mar 18, 1922, that I last saw him alive on Mar 18, 1922, and that death occurred, on the date stated above, at 8:05 P. M.

The CAUSE OF DEATH\* was as follows:

Bright's disease

(duration) yrs. mos. ds. CONTRIBUTORY (Secondary) Very cold.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. H. M. D.

(Address) 9692 Roland Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL

Cathedral March 22, 1922

UNDERTAKER ADDRESS

Horace H. Burge 3631 Fall Rd.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Chronic*

D 62631 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

38 D 62631

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST.: 76 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Hammond(a) RESIDENCE. NO. Unknown

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Unknown

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1867

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

54

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## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

New York

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Unknown

14

Informant Hospital Records,  
(Address) Municipal Hospital.

15

Filed

MAR 21 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1922

17

I HEREBY CERTIFY, That I attended deceased from  
February 24 1919 to March 19 1922.  
that I last saw him alive on March 18 1922.  
and that death occurred, on the date stated above, at 12:35 A.M.

The CAUSE OF DEATH\* was as follows:

Syphilis; Tabes dorsalis;  
Charcot's joints.duration 30 yrs. mos. ds.CONTRIBUTORY  
(Secondary)Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted  
If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Clayton McNeil M. D.  
3/20/22 Address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore CemeteryMar 21 1922

20 UNDERTAKER

ADDRESS

Edith Ambrose1723 W. L...

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62632

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2924

2-FULL NAME

(Residence in Baltimore: No. 2924

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female	4-COLOR OR RACE Chk	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
6-DATE OF BIRTH April 4, 1880		
7-AGE 71 yrs. 11 mos. 15 ds.	If LESS than 1 day, ... hrs. or ... min.	
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).		

9-BIRTHPLACE.  
(State or Country).

10-NAME OF FATHER Otto Gumbert	11-BIRTHPLACE OF FATHER (State or Country) Germany
12-MAIDEN NAME OF MOTHER Kubnauer	13-BIRTHPLACE OF MOTHER (State or Country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed..... 191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an

thereon and from the evidence obtained by said

The CAUSE OF DEATH\* WAS AS FOLLOWS

CONTRIBUTORY  
(Secondary)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS



D 62633

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 D 62633

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 14 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nannie Bell(a) RESIDENCE. NO. 1839 Druid Hill Ave ST.  WARD. 

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs.  mos.  ds. How long in U. S. if of foreign birth?  yrs.  mos.  ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?6 DATE OF BIRTH (month, day, and year) 18617 AGE Years 60 Months -- Days -- If LESS than 1 day, hrs. -- or min. --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Charles Co., Maryland  
(State or country)10 NAME OF FATHER Ben Procter11 BIRTHPLACE OF FATHER (city or town) Maryland  
(State or country)12 MAIDEN NAME OF MOTHER Esther Toney13 BIRTHPLACE OF MOTHER (city or town) Maryland  
(State or country)14 Informant Hospital Records,  
(Address) Municipal Hospital.15 Filed MAR 21 1922 19 1922 Registrar Lee

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 192217 I HEREBY CERTIFY, That I attended deceased from March 8 1922 to March 19 1922 that I last saw her alive on March 18 1922 and that death occurred, on the date stated above, at 6:35 A.M.  
The CAUSE OF DEATH\* was as follows:Chronic Myocarditis(duration) 2 yrs.  mos.  ds.CONTRIBUTORY  
(Secondary)(duration)  yrs.  mos.  ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of Was there an autopsy? YesWhat test confirmed diagnosis? Clyde M. Meneil M. D.3/20/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

MT Auburn Cemetery 3/2/2220 UNDERTAKER ADDRESS Robert E. Williams 1106 Ashland

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 62634

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62634

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE:

826 Parish  
Sallie Bedford  
826 Parish

ST.:

WARD)

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

(a) RESIDENCE. NO.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

15 yrs

mos

ds

How long in U. S., if of foreign birth?

yrs

mos

ds

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced (write the word)

Female Colored

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

44

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Domestic 041

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Laundry

(c) Name of employer

Self

9 BIRTHPLACE (city or town)  
(State or country)

Va

10 NAME OF FATHER

Toba Adams

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Va

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Unknown

14

Informant

Toba Adams

(Address)

Danville Va

15

Filed

19

MAR 21 1922

Registrar

16

112

ST.:

WARD)

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

(a) RESIDENCE. NO.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

15 yrs

mos

ds

How long in U. S., if of foreign birth?

yrs

mos

ds

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced (write the word)

Female Colored

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

44

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Domestic 041

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Laundry

(c) Name of employer

Self

9 BIRTHPLACE (city or town)  
(State or country)

Va

10 NAME OF FATHER

Toba Adams

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Va

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Unknown

14

Informant

Toba Adams

(Address)

Danville Va

15

Filed

19

MAR 21 1922

Registrar

16

112

ST.:

WARD)

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

(a) RESIDENCE. NO.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

15 yrs

mos

ds

How long in U. S., if of foreign birth?

yrs

mos

ds

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced (write the word)

Female Colored

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

44

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Domestic 041

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Laundry

(c) Name of employer

Self

9 BIRTHPLACE (city or town)  
(State or country)

Va

10 NAME OF FATHER

Toba Adams

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Va

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Unknown

14

Informant

Toba Adams

(Address)

Danville Va

15

Filed

19

MAR 21 1922

Registrar

16

112

ST.:

WARD)

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

(a) RESIDENCE. NO.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

15 yrs

mos

ds

How long in U. S., if of foreign birth?

yrs

mos

ds

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced (write the word)

Female Colored

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

44

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Domestic 041

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Laundry

(c) Name of employer

Self

9 BIRTHPLACE (city or town)  
(State or country)

Va

10 NAME OF FATHER

Toba Adams

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Va

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Unknown

14

Informant

Toba Adams

(Address)

Danville Va

15

Filed

19

MAR 21 1922

Registrar

16

112

ST.:

WARD)

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

(a) RESIDENCE. NO.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

15 yrs

mos

ds

How long in U. S., if of foreign birth?

yrs

mos

ds

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced (write the word)

Female Colored

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

44

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Domestic 041

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Laundry

(c) Name of employer

Self

9 BIRTHPLACE (city or town)  
(State or country)

Va

10 NAME OF FATHER

Toba Adams

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Va

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Unknown

14

Informant

Toba Adams

(Address)

Danville Va

15

Filed

19

MAR 21 1922

Registrar

16

112

ST.:

WARD)

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

(a) RESIDENCE. NO.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

15 yrs

mos

ds

How long in U. S., if of foreign birth?

yrs

mos

ds

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced (write the word)

Female Colored

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

44

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

62635

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

182 D 62635

1-PLACE OF DEATH

CITY OF BALTIMORE (No. ....)

2-FULL NAME

(Residence in Baltimore: No. ....)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

7-AGE,

IF LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-

FILE

MAR 21 1922

ROBERT H. KRAUTER

Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

(Coroner)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death, yrs., mos., ds. State, yrs., mos., ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

PUBLIC CEMETERY.

20-UNDERTAKER

ADDRESS

Commissioner Health,

For. Wm. E. WOODALL

MAR 21 1922

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62636

CERTIFICATE OF DEATH.

D 62636

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6-DATE OF BIRTH,

7-AGE.

11-LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FILE

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. ... mos. ... ds. State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

MAR 21 1922

Registrar.

JOHNS HOPKINS HOSPITAL

19...

MAR 2 1922



state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should

# HEALTH DEPARTMENT—CITY OF BALTIMORE

62637

## CERTIFICATE OF DEATH.

Registered No. **D 62637**

### 1-PLACE OF DEATH

City of BALTIMORE: (No. **1122 Olive Street.** St. **23** Ward)

### 2-FULL NAME

**Enna McDonald. (C).**

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. **1122 Olive Street.** St.; yrs. **5** mos. **5** ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, **Female.** 4-COLOR OR RACE, **Colored.** 5-Single, Married, Widowed, or Divorced, (Write the word.) **Single**

6-DATE OF BIRTH, **Do not know.** 1. (Month) (Day) (Year)

7-AGE, **39** yrs. -- mos. --- ds. If LESS than 1 day, hrs. or min.?

### 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. **None.** (b) General nature of industry, business, or establishment in which employed (or employer).

### 9-BIRTHPLACE, (State or Country),

**Calvert Co. Md.**

10-NAME OF FATHER, **Do not know.**

11-BIRTHPLACE OF FATHER, (State or Country), **Do not know.**

12-MAIDEN NAME OF MOTHER, **Do not know.**

13-BIRTHPLACE OF MOTHER, (State or Country), **Do not know.**

### 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Samuel Hall. (C).**

(Address) **1122 Olive Street.**

15- **MAR 21 1922** **ROBERT R. KRAUTER** Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, **March 12th, 1922.** (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an **inquiry** (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said **inquiry** and that said deceased came to **her** death (Inquest, autopsy or Inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

**Lobar Pneumonia.**

### CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds. (Signed) **Thomas P. Reinhardt** M. D. (Coroner) Mar. 14, 1922. (Address) **1014 S. Charles St.**

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER, ADDRESS

**MAR 2 1922**

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62638

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 717 Curtis Ave. St. 25 170 Ward)

2-FULL NAME..... Jacob Kruk.

(Residence in Baltimore: No. 717 Curtis Ave. St.; yrs. 2 mos. ds.)

Registered No. C. D 62638

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH. Do not know. (Month) (Day) (Year)

7-AGE. 24 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Laborer (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Russia.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER, (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Police Report.

(Address).

15- MAR 21 1922 ROBERT R. KRAUTER, Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 13th, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows: Laceration and hemorrhage of the Brain. Pistol shot wound in the head. Suicide.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. R. Reinhardt, M. D. (Coroner)

Mar. 20, 1922. (Address) 1517 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

HOPKINS HOSPITAL 19

20-UNDERTAKER, ADDRESS

Commissioner Health, MAR 21 1922

19030 THE MORGUE.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62639

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62639

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *31* Ward)

2-FULL NAME

(Residence in Baltimore: No. *1636 Pratt St.* St.; yrs. .... mos. .... ds.)

Registered No. C. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*male*

4-COLOR OR RACE,

*white*

5-Single,

*Married*  
Widowed,  
or Divorced,  
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

*35*

yrs. .... mos. .... ds.

If LESS than 1 day,

.... hrs. or .... min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country),

*Poland.*

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER,  
(State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER,  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed

MAR 21 1922

ROBERT R. KRAUTER,

Burial Permit Clerk,

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

*Mar 15 22*  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an..... (Inquest, autopsy or inquiry.)

inquest and from the evidence obtained by..... (Inquest, autopsy or inquiry.)

find that said deceased came to..... death

on the day stated above.

The CAUSE OF DEATH was as follows:

*Adrenaline*  
*J.B. Pub.*

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTOR  
(Secondary)

(Signed)..... M. D.

(Address).....

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF

20-UNDERTAKER,

ADDRESS

D 62640

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 62640

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *425 E. Lafayette Ave*)WARD *17*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mary L. Brookhart*(a) RESIDENCE. NO. *425 E. Lafayette Ave*

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *40* yrs. — mos. — ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced

(or) WIFE of *George W Brookhart*6 DATE OF BIRTH (month, day, and year) *Dec 18th 1861*

7 AGE

Years *60*Months *3*Days *—*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Home work*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Waterford, Pa*  
(State or country) *Pa*10 NAME OF FATHER *Wm Hyland*11 BIRTHPLACE OF FATHER (city or town) *Waterford*  
(State or country) *Pa*12 MAIDEN NAME OF MOTHER *Mary Quinn*13 BIRTHPLACE OF MOTHER (city or town) *Waterford*  
(State or country) *Pa*

14

Informant *Mrs Cecilia Dvoran*(Address) *425 E. Lafayette Ave*

15

MAR 21 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 18th 1922*

17

I HEREBY CERTIFY, That I attended deceased from *March 7th*, 1922, to *March 18th*, 1922, that I last saw her alive on *March 18th*, 1922, and that death occurred, on the date stated above, at *— 9 P. m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Myocarditis*(duration) *one* yr. *7* mos. *—* ds.

CONTRIBUTORY (Secondary)

*Chronic Intestinal*  
*Nephritis* (duration) *two* yrs. *4* mos. *—* ds.18 Where was disease contracted if not at place of death? *Place of death*Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Chronic Myocarditis*  
(Signed) *M. J. Dvoran*, M. D.3/19/22 (Address) *1701 N. Fulton Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Grindridge Cemetery* *Mar 22 1922*

20 UNDERTAKER

ADDRESS

*Isiah Syer 1600 W North Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62641

D 62641

## CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MAR 21 1922

191

ROBERT R. KRAUTER,

Burial Permit Clerk.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an

thereon and from the evidence obtained by said

and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

bullet wound in chest  
Hemorrhage

CONTRIBUTORY (Secondary)

(Signed)

3-24, 1912

(Address) 117 N. Sargent

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs... mos... ds. In the State... yrs... mos... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62642

1-PLACE OF DEATH

D 62642

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 133 E. Gettling

ST. 24 WARD)

2-FULL NAME Lillian Eunice Gehring

(a) RESIDENCE. No. 133 E. Gettling

ST. 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 9, 1919

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

2

6

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) V. Balto. Md.  
(State or country)

10 NAME OF FATHER Leonard P. Gehring

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

V. Balto. Md.

12 MAIDEN NAME OF MOTHER Lillian Wood.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

V. Balto. Md.

14

Informant Lillian Gehring

(Address)

133 E. Gettling

15

MAR 21 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 20 1922

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 9, 1922, to Mar. 20, 1922,

that I last saw her alive on Mar. 19, 1922,

and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH\* was as follows:

Failure of Pericardial Cocles to close.

(duration) Life yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. J. Seabury, M. D.

3/20 1922 (Address) 638 Fock

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cedar Hill.

DATE OF BURIAL

3-22 1922

20 UNDERTAKER

Er B. Harber 115 E. West St.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -1-10-21-M&T-1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62643

CERTIFICATE OF DEATH.

31

D 62643

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 scott

ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lula Katherine Green

(a) RESIDENCE NO. 524 Scott  
(Usual place of abode)

ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 9 1889

7 AGE Years 33 Months I Days II If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland

10 NAME OF FATHER William Green

11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Reed

13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country) Maryland

14 Informant Mrs. L.W. Phillips  
(Address) 2804 Guilford Ave.

15 MAR 21 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 19 21 to Mar 20 19 22, that I last saw her alive on Mar 20 19 22, and that death occurred, on the date stated above, at 1:45 P.M.  
The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis  
(duration) yrs. 3 mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyd, M. D.

(Address) 672 Columbia Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park Cemetery  
20 UNDERTAKER Joseph B. Cook  
DATE OF BURIAL Mar 22 1922  
ADDRESS 1003 N. Baltimore

D 62644

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62644

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2234 E Oliver ST., 8 WARD)

## 2. FULL NAME

(a) RESIDENCE NO. 2234 E Oliver ST., 8 WARD

(Usual place of abode)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel A Redell6 DATE OF BIRTH (month, day, and year) Jan 12 18977 AGE Years 25 Months 2 Days 7 If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packer 086(b) General nature of industry, business, or establishment in which employed (or employer) Chair Factory(c) Name of employer Hegwood Bros & Co9 BIRTHPLACE (city or town) Baltimore  
(State or country)10 NAME OF FATHER Daniel Redell11 BIRTHPLACE OF FATHER (city or town) Pittsburg  
(State or country) Pa12 MAIDEN NAME OF MOTHER Mary James13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country)14 Informant Ethel Redell  
(Address) 2234 E. Oliver st15 MAR 21 1922 ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20 192217 I HEREBY CERTIFY, That I attended deceased from March 18, 1922, to March 19, 1922, that I last saw him alive on March 19, 1922, and that death occurred, on the date stated above, at 1 9 m. The CAUSE OF DEATH\* was as follows:Acute Peritonitis. from  
Perforating Duodenal Ulcer  
(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) — (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. H. Herzog, M. D.Address) 1305 N Patterson Pl

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St Peters Cemetery 3/22/22

20 UNDERTAKER

Ed Krause & Son 703 N. Avenue

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62645

## CERTIFICATE OF DEATH.

D 62645

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Home for Incurables* ST.; *12* WARD)

## REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*Laura V. Addison*(Residence in Baltimore: No. *Home for Incurables* St.; *12* yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *single* (Write the word.)

## 6-DATE OF BIRTH,

*Oct 10<sup>th</sup>, 1852*  
(Month) (Day) (Year)

## 7-AGE,

*63 yrs. 5 mos. 10 ds.*

## IF LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *none*(b) General nature of industry, business, or establishment in which employed (or employer), *do*

## 9-BIRTHPLACE, (State or Country),

*Baltimore Md*

## 10-NAME OF FATHER,

*Wm W Addison*

## 11-BIRTHPLACE OF FATHER (State or Country),

*city, Md*

## 12-MAIDEN NAME OF MOTHER

*Susanna Otter*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*city Md*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Geo W Little*(Address) *2700 Edmondson*

## 15-

*Robert P. Harrison,*

## Filed

191

Registrar.

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*March 20, 1922*  
(Month) (Day) (Year)

## I HEREBY CERTIFY, That I attended deceased from

*Jan 1921 to March 20 1922,*that I saw her alive on *March 20 1922,*and that death occurred, on the date stated above, at *9 P. m.*

The CAUSE OF DEATH\* was as follows:

*Myocarditis Acicular**fibrillation*(Duration) *1* yrs. *1* mos. *1* ds.

## CONTRIBUTORY (Secondary)

*Acute Bronchitis*(Duration) *6* yrs. *6* mos. *6* ds.(Signed) *W. W. Mayo* M. D.*March 21 1922* (Address) *Baltimore*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*St. Glivier*

## DATE OF BURIAL,

*March 23 1922*

## 20-UNDERTAKER

*Geo. W. Little*

## ADDRESS

*2700 Edmondson**Jan*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62646

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *1313 Archer* ST., *16* WARD)2-FULL NAME *Daniel Shanahan*(a) RESIDENCE NO. *1313 Archer St.* ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M.*4 COLOR OR RACE *Irish*5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced, HUSBAND *Mary Coen*6 DATE OF BIRTH (month, day, and year) *Jan 18 1861*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*61*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Coiler Worker*(b) General nature of industry, business, or establishment in which employed (or employer) *886*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Ireland*10 NAME OF FATHER *Paul Shanahan*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ireland*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*

14

Informant (Address) *Mary Shanahan 1313 Archer St.*

15

*Robert P. Harrison,*

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 18 1922*

17

I HEREBY CERTIFY That I attended deceased from *Feb. 18 1922* to *March 10 1922*, that I last saw him alive on *March 10 1922*, and that death occurred, on the date stated above, at *11:00 P.M.*

The CAUSE OF DEATH\* was as follows:

*Periculous Anemia*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

(If not at place of death?) *No*Did an operation precede death? *No* Date of *No*Was there an autopsy? *No*What test confirms diagnosis? *Blood exam. (micro)*(Signed) *Barth. E. Gaggott, M.D.*, 19 (Address) *1207 Mosher St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

CAUSE OF DEATH should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT-CITY OF BALTIMORE

D 62647

## CERTIFICATE OF DEATH

90 D 62647

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

1409 Lowman St.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

John E. Abbott

Residence in Baltimore: No.

1409 Lowman St.

Str. yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

, 1890  
(Month) (Day) (Year)

7 AGE

32

yrs. mos. ds. or min.?

If LESS than

1 day, hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Blaine Gang Worker

Dry Dock Balto

9 BIRTHPLACE

(State or country)

Balto Md

10 NAME OF FATHER

George W. Abbott

11 BIRTHPLACE OF FATHER

(State or country)

Balto Md

12 MAIDEN NAME OF MOTHER

Margaret Booth

13 BIRTHPLACE OF MOTHER

(State or country)

Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harold Abbott

(Address)

1409 Lowman St.

15

Robert P. Harrison,

191 Permit Clerk.

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 19, 1912  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 19, 1911, to March 19, 1912

that I saw him alive on March 18, 1912

and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH\* was as follows:

Acute dilatation of heart

(Duration) yrs. mos. ds.

Contributory Acute Regurgitation  
(SECONDARY)

(Duration) yrs. 3 mos. ds.

(Signed) Thomas A. Stevens M.D.

3/20, 1912 (Address) 2878 Hayford St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cathedral Cem

3/22, 1912

20 UNDERTAKER

ADDRESS

J. J. Haynes

1318 Light St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62648

## CERTIFICATE OF DEATH.

D 62648

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

1728 E. Lombard St.

ST.:

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Josiah Almany

## (a) RESIDENCE. NO.

1728 E Lombard St.

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

3 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

2 yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Widowed

## 5a If married, widowed, or divorced—

HUSBAND of

Margaret Duncan

## 6 DATE OF BIRTH (month, day, and year)

June 6, 1829

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

92

9

1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Retired

## 9 BIRTHPLACE (city or town)

Harford Co

(State or country)

## 10 NAME OF FATHER

Abram Almany

## PARENTS

## 11 BIRTHPLACE OF FATHER (city or town)

Harford Co

(State or country)

## 12 MAIDEN NAME OF MOTHER

Sarah Gardner

## 13 BIRTHPLACE OF MOTHER (city or town)

Harford Co

(State or country)

## 14

Informant

(Address)

J. S. Dunlap

1728 E Lombard St

## 15

Filed

Robert F. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1921

17

I HEREBY CERTIFY, That I attended deceased from

Jan 1921, to Mar 20, 1921

that I last saw him alive on Mar 20, 1921,

and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH\* was as follows:

Chronic nephritis.

## CONTRIBUTORY (Secondary)

(duration) 3 yrs. — mos. — ds.

Senility.

(duration) — yrs. — mos. — ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis.

(Signed) M. J. Hanna, M. D.

19 (Address) 1822 W Baltimore

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Wesley Chapel

## DATE OF BURIAL

Mar 23 1922

## 20 UNDERTAKER

E. J. Kintz &amp; Son

## ADDRESS

Jarrett

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

R21 1922



D 62649

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62649

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1210 Main St. ST. 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roland Baker(a) RESIDENCE, No. 1210 Main St. ST. 25 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 27, 19217 AGE Years 2 Months 11 Days 21 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md. (State or country)10 NAME OF FATHER Roland Baker11 BIRTHPLACE OF FATHER (city or town) Balto, Md. (State or country)12 MAIDEN NAME OF MOTHER Cecilia Meyers13 BIRTHPLACE OF MOTHER (city or town) Balto, Md. (State or country)14 Informant Cecilia Meyers (Address) 1210 Main St. Baltimore15 Filed Robert P. Hartwood, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-20-2217 I HEREBY CERTIFY, That I attended deceased from 3-20-, 1922, to 3-20-22, 1922, that I last saw him alive on 3-20-22, 1922, and that death occurred, on the date stated above, at 3:30 pm.

The CAUSE OF DEATH\* was as follows:

Intestinal Intussusception(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Richard Drain, M. D., 19 (Address) 1227 Columbia St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

Geo. P. Schwab 410 Biddle St.

APR 1 1922

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62650

D 62650

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2228 E. Preston Place ST.: 8 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine M. Prochaska(a) RESIDENCE. NO. 2228 E. Preston Place ST. 8 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of Andrew C. Prochaska (or) WIFE of6 DATE OF BIRTH (month, day, and year) March 18947 AGE 28 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bohemia (State or country)10 NAME OF FATHER Nemecsek11 BIRTHPLACE OF FATHER (city or town) Bohemia (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Bohemia (State or country)14 Informant Andrew C. Prochaska (Address) 2228 E. Preston Place15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1922

17

I HEREBY CERTIFY, That I attended deceased from October 18th, 1921, to March 17th, 1922, that I last saw her alive on March 17th, 1922, and that death occurred, on the date stated above, at 10 a.m. The CAUSE OF DEATH\* was as follows:Pulmonary Tuberculosis(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? T.B. in sputum(Signed) Wm. Conrad Fode, M. D.19 (Address) 1901 Maryland Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Oak Hill Cemetery Mar 23 1922

20 UNDERTAKER

ADDRESS

for freudens son 217 S. Bea

R21 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62651

## CERTIFICATE OF DEATH.

31

D 62651

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 Beacon ST., 24 WARD)

## 2. FULL NAME

Frank Mosakowski

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1629 Beacon

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

20

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

20

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Helen Mosakowski

6 DATE OF BIRTH (month, day, and year)

unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

5100

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Shedder

(b) General nature of industry, business, or establishment in which employed (or employer)

874

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Poland

10 NAME OF FATHER

Joseph Mosakowski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Helena Musienko

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

## PARENTS

14 Informant (Address)

Helen Mosakowski  
1629 Beacon St.

## 15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21, 1922

17

HEREBY CERTIFY, That I attended deceased from September, 1921, to March, 1922, that I last saw him alive on March 19, 1922, and that death occurred, on the date stated above, at 6:30 p.m. The CAUSE OF DEATH\* was as follows:Tuberculosis Pulmonum  
(duration) 1 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 1 1/2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) E. S. Murr M. D.

1, 2, 1922 (Address)

801 V. E. St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St. Mary's Rosary3/21 1922

FUNERAL

ADDRESS

1629 Beacon St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 62652

## CERTIFICATE OF DEATH.

131 D 62652

1-PLACE OF DEATH

841 S. Dallas St.

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mary Wujek

(Residence in Baltimore: No.

841 S. Dallas St.

St.; 18 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

Dec 2, 1904

7-AGE,

18

If LESS than 1 day.

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE,  
(State or Country),

Baltimore Md.

10-NAME OF FATHER,

Andrew Wujek

11-BIRTHPLACE OF FATHER  
(State or Country),

Poland

12-MAIDEN NAME OF MOTHER

Victoria Czajkowski

13-BIRTHPLACE OF MOTHER  
(State or Country),

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Andrew Wujek

(Address)

841 S. Dallas St.

15-

Filed

Robert M. Harrison,

Registrar.

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Feb 18, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Mar 1, 1912, to Mar 19, 1922

that I saw her alive on Mar 19, 1922.

and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH\* was as follows:

Supper abdominal

(Duration)....yrs....mos....ds.

CONTRIBUTORY  
(Secondary)

(Duration)....yrs....mos....ds.

(Signed)

M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62653

## CERTIFICATE OF DEATH.

31 D 62653

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 W. Carey ST. 16 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 1008 W. Carey St.: 29 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, Celoid 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, married (Write the word.)6-DATE OF BIRTH, Feb 27, 1893 (Month) (Day) (Year)7-AGE, 29 yrs., mos. ds. If LESS than 1 day, ....hrs. or....min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, Homekeeper (b) General nature of industry, business, or establishment in which employed (or employer), 10399-BIRTHPLACE, (State or Country), Bath, City10-NAME OF FATHER, Charles H James11-BIRTHPLACE OF FATHER, (State or Country), Bath, Ind12-MAIDEN NAME OF MOTHER, Mollie Watkins13-BIRTHPLACE OF MOTHER, (State or Country), Bath, City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mollie James(Address) 1008 W. Carey St

15-

21-1922 Robert P. Harrison, Registrar.

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 20, 1922 (Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1922, to Mar 20 1922, that I saw her alive on Mar 18 1922, and that death occurred, on the date stated above, at 2:30 a. m. The CAUSE OF DEATH\* was as follows:Pulmonary  
Tuberculosis  
(Duration) ....yrs....mos....ds.CONTRIBUTORY, Exhaustion (Secondary)(Signed) W. S. Hughes M. D.Mar 20, 1922 (Address) 637 Mocher St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, W. T. Auburn Cemetery DATE OF BURIAL, March 23 192220-UNDERTAKER, John B. Pyle ADDRESS, 101 E Mulberry St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62654

## CERTIFICATE OF DEATH.

D 62654

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1500 Argyle Ave. ST. 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert C. Lee(Residence in Baltimore: No. 1500 Argyle Ave St.; 1 yrs. 1 mos. 1 da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Colored5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

January 231932

7-AGE,

1 month 28 days

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. None(b) General nature of industry, business, or establishment in which employed (or employer) 0009-BIRTHPLACE, (State or Country), Beth City

PARENTS.

10-NAME OF FATHER, Charles Lee11-BIRTHPLACE OF FATHER (State or Country) Charles Co Md12-MAIDEN NAME OF MOTHER Sophronia Tate13-BIRTHPLACE OF MOTHER (State or Country), Beth City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sophronia Lee(Address) 1500 Argyle Ave.

15-

Robert E. Harrison,

Filed

191

R21 1922

Burial Permit Clerk. Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. 21, 1932

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from Mar 20 1932 to Mar. 21 1932that I saw him alive on Mar. 20 1932and that death occurred, on the date stated above, at 5-9 m.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia(Duration) 5 yrs. 2 mos. 2 ds.CONTRIBUTORY (Secondary) Asthma(Duration) 5 yrs. 2 mos. 2 ds.(Signed) W. V. Carr M. D.Mar 21 1932 (Address) 515 Madison

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 1 mos. 1 ds. In the State 1 yrs. 1 mos. 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Green CemeteryDATE OF BURIAL, March 22 1932

20-UNDERTAKER

Felix B. Rye 102 E. Mulberry St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -1-10-21-M&T-1500 Bks.

D 62655

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175 D 62655

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3518 Parkdale ave. ST. 13 WARD)

2. FULL NAME Mary C. Wink

(a) RESIDENCE NO. 3518 Parkdale ave. WARD

(Usual place of abode) Length of residence in city or town where death occurred yrs. 3 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 6, 1921

7 AGE Years 3 Months 14 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto M.D.  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) M.D.  
(State or country)

12 MAIDEN NAME OF MOTHER Alice L. Waller

13 BIRTHPLACE OF MOTHER (city or town) M.D.  
(State or country)

14 Informant John Wink  
(Address) 3518 Parkdale ave.

15 Robert P. Earlson, Registrar

1921 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20 1922

17 I HEREBY CERTIFY, That I attended deceased from 3-19 1922 to 3-20 1922

that I last saw him alive on 3-20 1922

and that death occurred, on the date stated above, at 2:30 pm.

The CAUSE OF DEATH\* was as follows:

Gastro-enteritis (Acute)  
(duration) yrs. mos. 2 ds.

CONTRIBUTORY Stomach infection  
(Secondary) (duration) yrs. mos. 2 ds.

18 When was disease contracted (if not at place of birth) at home

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Physical signs

(Signed) C. F. Hume M. D.

Address 3701 Reisterstown Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge DATE OF BURIAL Mar 22 1922

20 UNDERTAKER Chenoweth & Son ADDRESS Chestnut

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62656

D 62656

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Volunteers of America Hosp.* REGISTERED NO.CITY OF BALTIMORE: (No. *418 W. Lexington* ST.: *1* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Samuel Jarden*(a) RESIDENCE. No. *418 N. Greene* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *1 yr.* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*

If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Elizabeth Jarden*6 DATE OF BIRTH (month, day, and year) *Nov 8-70*7 AGE Years *46* Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Electrician*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Maryland*9 BIRTHPLACE (city or town) (State or country) *Maryland*10 NAME OF FATHER *unknown*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Maryland*12 MAIDEN NAME OF MOTHER *unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *unknown*14 Informant *Laurence Moller*  
(Address) *418 N. Greene*15 Filed *March 1 1922* *Robert P. Bartlett*, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-21* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *3-16*, 19 *22*, to *3-21*, 19 *22*.that I last saw him alive on *3-21*, 19 *22*.and that death occurred, on the date stated above, at *10:30 A.M.*

The CAUSE OF DEATH\* was as follows:

*Acute Pneumonia complicating some cerebral spinal lesion*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Edema of lungs*  
(duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? *418 N. Greene St.*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *yes*(Signed) *J. H. Payanwall*, M. D., 19 (Address) *418 N. Lexington*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Woodlawn**3/23* 19 *22*

20 UNDERTAKER

ADDRESS

*William Cook**502 E. North*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 21 1922



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62657

D 62657

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 729 N. Fremont ST. 17 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Charles H. Andrae

## (a) RESIDENCE. NO.

729 N. Fremont

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 6 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

male

## 4 COLOR OR RACE

white

## 5 Single, Married, Widowed, or Divorced (write the word)

single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Sept 6 1859

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

62

6

14

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired Poultry Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

045

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

## 10 NAME OF FATHER

Christian Andrae

## PARENTS

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Catherine Eisenberg

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

## 14

Informant (Address)

Miss Clara Andrae 729 N. Fremont Ave

## 15

Robert P. Harrison,

Registrar

21 1922

Special Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 9 1921, to Mar 20 1922, that I last saw him alive on Mar. 20 1922, and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH\* was as follows:

Malignant Endocarditis

(duration) yrs. 4 mos. 11 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinal Clinical

(Signed) C. McDonald M. D.

Address 1540 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

London Park Cemetery

March 22 1922

## 20 UNDERTAKER

## ADDRESS

Chas. G. Black

742 W. North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62658

## CERTIFICATE OF DEATH.

90 D 62658

## 1-PLACE OF DEATH

CITY OF BALTIMORE, (No. *1117 Shields Alley* ST.; *17* WARD)

## REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *1117 Shields Alley* St.; *50* yrs., *0* mos., *0* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Female*

## 4-COLOR OR RACE,

*Celoid*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

## 6-DATE OF BIRTH,

*Unknown*

(Month) (Day) (Year)

## 7-AGE,

*61*yrs., *0* mos., *0* ds.

If LESS than 1 day,

...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Laundress*  
*Private Homes*

## 9-BIRTHPLACE, (State or Country),

*MD*

## 10-NAME OF FATHER,

*Unknown*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Unknown*

## 12-MAIDEN NAME OF MOTHER

*Unknown*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Unknown*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mabel Bradley*(Address) *1117 Shields*

## 15-

MAR 22 1922

ROBERT R. KRAUTER,

File

Burial Permit Registered

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Mar 21, 1922*  
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *Mar 17, 1922*, to *Mar 21, 1922*, that I saw her alive on *Mar 20, 1922*, and that death occurred, on the date stated above, at *8:50 a.m.*

The CAUSE OF DEATH\* was as follows:

*Hypostatic Pneumonia*(Duration) *4* yrs., *0* mos., *0* ds.

## CONTRIBUTORY (Secondary)

(Duration) *3* yrs., *0* mos., *0* ds.(Signed) *William E. Burton* M. D.*Mar 21, 1922*, (Address) *762 Dolphin*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *0* yrs., *0* mos., *0* ds. In the State *0* yrs., *0* mos., *0* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

*St. Auburn Cem.* *Mar 24, 1922*

## 20-UNDERTAKER

## ADDRESS

*Chris. H. Johnson* *437 N. Carroll**446 N. Carroll*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62659

## CERTIFICATE OF DEATH.

D 62659

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413-415 W. BiddleST.: More WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Jackson(a) RESIDENCE. NO. 541 Wilson

(Usual place of abode)

ST.,

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

28

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Janitor 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Onulis-9 BIRTHPLACE (city or town) (State or country) Glen Dale Md10 NAME OF FATHER William Jackson Sr

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland12 MAIDEN NAME OF MOTHER Alice Wilson

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

## 14

Informant Julia Bryant(Address) 541 Wilson

## 15

Filed

19

MAR 22 1922

ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1922

## 17

I HEREBY CERTIFY, That I attended deceased from March 14, 1922, to March 21, 1922.that I last saw him alive on March 20, 1922.and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH\* was as follows:

Interstitial Nephritis(duration) yrs. 4 mos. 4 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. none mos. 4 ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Urinary Phosphorus(Signed) Wm H. Major M. D.21, 1922 (Address) 1209 Presstman St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Glen Dale MdMar 22 1922

## 20 UNDERTAKER

## ADDRESS

Samuel J. Buckley541 W Biddle St

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62660

## CERTIFICATE OF DEATH.

74-001 D 62660  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *119 W. Henrietta* ST. *23* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*Thomas Landin*(Residence in Baltimore: No. *119 W Henrietta*St. *23* yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*male*

## 4-COLOR OR RACE,

*colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*

## 6-DATE OF BIRTH,

*Apr. 25, 1862*  
(Month) (Day) (Year)

## 7-AGE,

*60 yrs. 10 mos. 22 ds.*

If LESS than 1 day,

...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

*Oyster Shucker*

(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE,

(State or Country),

*Maryland*

## 10-NAME OF FATHER,

*Thomas Landin*

## 11-BIRTHPLACE OF FATHER

(State or Country),

*Maryland*

## 12-MAIDEN NAME OF MOTHER

*Rosetta Bailey*

## 13-BIRTHPLACE OF MOTHER

(State or Country),

*Maryland*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Barbara Landin*(Address) *119 W Henrietta St*

15-

Filed

191

ROBERT H. KRAUTER

Bureau of Vital Statistics

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Mich. 19, 1922*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*for two years*, to *Mich. 14, 1922*  
that I saw him alive on *Mich. 14, 1922*and that death occurred, on the date stated above, at *730* m.

The CAUSE OF DEATH\* was as follows:

*Immediate - Hemiplegia & Exhaustion**Primary - Paralysis**Last attack (Duration) yrs. mos. ds.*

## CONTRIBUTORY (Secondary)

*arteriosclerosis*(Signed) *J. P. Thompson* M. D.*Mich. 21, 1922* (Address) *578 W. Biddle*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*St. Ambrose**3/22, 1922*

## 20-UNDERTAKER,

## ADDRESS

*Samuel Newberry**578 W. Biddle*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 22 1922



D 62661

HEALTH DEPARTMENT—CITY OF BALTIMORE D 62661

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 H. Dallas ST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Wilburn

(a) RESIDENCE, NO. 412 H. Dallas ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE col. 5 Single, Married, Widowed, or Divorced (write the word) Married.

5a If married, widowed, or divorced HUSBAND of Elizabeth Wilburn

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years Months Days If LESS than 1 day, hrs. or min. Over 10

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer

9 BIRTHPLACE (city or town) Hartford, Conn. (State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Hartford, Conn. (State or country)

12 MAIDEN NAME OF MOTHER Annie Harris

13 BIRTHPLACE OF MOTHER (city or town) Hartford, Conn. (State or country)

14 Informant Samuel J. Wilburn (Address) 412 H. Dallas St.

15 Filed MAR 22 1922 ROBERT R. KRAUTER Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Mar 1922

17 I HEREBY CERTIFY, That I attended deceased from 13 Mar 1922, to 19 Mar 1922, that I last saw him alive on 19 Mar 1922, and that death occurred, on the date stated above, at 1:30 p. m. The CAUSE OF DEATH\* was as follows: Infected tooth

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopical

(Signed) Mayfield B. M. D.

(Address) 412 H. Dallas St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn Cemetery

DATE OF BURIAL

20 UNDERTAKER Samuel Wilburn

ADDRESS

578 W. Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

No tuberculosis  
infection and  
no malignant  
disease.

Wm. Byrd

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

## CERTIFICATE OF DEATH.

157 D 62662

1. PLACE OF DEATH

CITY OF BALTIMORE: (NO.

JOHNS HOPKINS HOSPITAL ST., 23 WARD)

57 D 62662  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Eother Frazier

(a) RESIDENCE NO.

1011 S. Howard St.

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Unknown

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

Black

Widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 2, 1855

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

67

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Maryland

10 NAME OF FATHER

?

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Henrietta Pritchett

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Maryland

14

Informant  
(Address)JOHNS HOPKINS HOSPITAL  
Sec 23

15

Filed

MAR 22 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

16

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Mt. Auburn

DATE OF BURIAL

Mch 23, 22

20 UNDERTAKER

John H. Treadwell

ADDRESS

142  
Artie St

16 DATE OF DEATH (month, day, and year)

March 21, 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 18, 1922, to March 20, 1922,

that I last saw him alive on March 20, 1922,

and that death occurred, on the date stated above, at 3:45 p.m.

The CAUSE OF DEATH\* was as follows:

Acidosis

Unknown (duration) Insidious onset yrs. mos. ds.

CONTRIBUTORY Diabetes mellitus; gangrene of foot  
(Secondary)

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical analysis of blood

(Signed) Francis R. Drenth, M. D.

1922 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

D 62663

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62663

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 S. Eutaw ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard C. Gordon(a) RESIDENCE. NO. 810 S. Eutaw ST. 21 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 1-19217 AGE Years 1 Months 1 Days 19 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)10 NAME OF FATHER Harry Gordon11 BIRTHPLACE OF FATHER (city or town) md (State or country)12 MAIDEN NAME OF MOTHER Elcie Bush13 BIRTHPLACE OF MOTHER (city or town) md (State or country)

14

Informant Harry Gordon (Address) 810 S. Eutaw St

15

MAR 22 1922

ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20 1922

17

I HEREBY CERTIFY, That I attended deceased from Mar 1, 1922, to Mar 20, 1922, that I last saw him alive on Mar 20, 1922,and that death occurred, on the date stated above, at 4:45 p.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia & Lobar

CONTRIBUTORY (Secondary)

(duration) 20 yrs. mos. ds.

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? NoneDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Autopsy & X-ray(Signed) W. H. H. H. H. M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Auburn 3-22 1922

20 UNDERTAKER

John H. Toadum ADDRESS 142

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state EXACTLY.



Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. - I-10-21 - M&T - 1500 Bks.

HEALTH DEPARTMENT - CITY OF BALTIMORE

D 62664

CERTIFICATE OF DEATH.

90 D 62664

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes Hospital*)

2-FULL NAME

(a) RESIDENCE NO. *312 S. Moodyeas St.*

(Usual place of abode)

Length of residence in city or town where death occurred

ys. mos. ds.

How long in U. S., if of foreign birth?

ys. mos. ds.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAR 22 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from March 11, 1922, to March 21, 1922, that I last saw him alive on March 21, 1922, and that death occurred, on the date stated above, at 12:00 m.

The CAUSE OF DEATH\* was as follows:

Myocardial insufficiency  
coronary thrombosis of  
right ventricle  
(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62665

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 826 HOLLINS

ST.: 18 WARD)

2-FULL NAME ANDRUS TWARONAS

(a) RESIDENCE. NO. 826 HOLLINS

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX  
MALE4 COLOR OR RACE  
WHITE5 Single, Married, Widowed,  
or Divorced (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 2th 1919

7 AGE 2 Years 5 Months 19 Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) BALTIMORE Md  
(State or country)

10 NAME OF FATHER ZIGMANTAS TWARONAS

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) LITHVANIA

12 MAIDEN NAME OF MOTHER K. STURSUTE

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) LITHVANIA14 Informant ZIGMANTAS TWARONAS  
(Address) 826 HOLLINS STREET

15 Filed

19

MAR 22 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-21-22

17 I HEREBY CERTIFY, That I attended, deceased from

March 11, 1922, to March 21, 1922

that I last saw him live on March 21, 1922

and that death occurred, on the date stated above, at 6 p.m.

The CAUSE OF DEATH\* was as follows:

Diphtheria (Pharyngeal)

Sepsis Broncho Pneumonia

CONTRIBUTORY (Secondary) Sepsis Broncho Pneumonia

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinical

(Signed) M. B. Drilling M. D.

21-22 (Address) 682 Columbia Ave

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

HOLY REDEEMER

3/22. 1922

20 UNDERTAKER

ADDRESS

JOHN GREBLIAUCKAS

425 S. PACA

ST

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62666

90 D 62666

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

1223 Brief court

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO.

ST. 10 WARD)

2-FULL NAME

Estes E. Smith

(a) RESIDENCE, NO.

1223 Brief court

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Col.

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year)

April 3, 1910

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1 1/2 !!

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

100

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Beatrice Cornish

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto.

14

Informant

(Address)

Mrs Mary Smith  
1223 Brief court

MAR 22 1922

ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1922

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1922, to March 20, 1922, that I last saw her alive on March 19, 1922, and that death occurred, on the date stated above, at 10 A. M. The CAUSE OF DEATH\* was as follows:

Cerebral Trauma, Baltimore

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 14 ds.

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Character L. S. Engle

(Signed)

C. H. Howler

M. D.

(Address)

712 Sharp Street

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laurel Cem.

March 22 1922

20 UNDERTAKER

ADDRESS

Mrs J. G. Locks

1302 Jefferson St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62667

90 D 62667

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH  
CITY OF BALTIMORE (No. 2712 Hampden Ave. 17 WARD)  
2-FULL NAME Mary Catherine Eaton  
(Residence in Baltimore: No. 2712 Hampden St.; yrs. 30 mos. da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female  
4-COLOR OR RACE White  
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married  
6-DATE OF BIRTH, Aug 15, 1867  
(Month) (Day) (Year)  
7-AGE, 54 yrs. 7 mos. 5 da. If LESS than 1 day, ... hrs. or ... min.?  
8-OCCUPATION: (a) Trade, profession, or particular kind of work... Housewife (b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Pa

10-NAME OF FATHER, John Lee  
11-BIRTHPLACE OF FATHER, Pa  
12-MAIDEN NAME OF MOTHER, Asked not known  
13-BIRTHPLACE OF MOTHER, Asked not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) Samuel H. Eaton  
(Address) 2712 Hampden Ave.

15-

MAR 22 1922

ROBERT R. KRAUTER,  
Registrar,  
Burial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 20, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Calculus disease of heart  
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Signed) John H. Johnson  
(Coroner)  
Mar 21 1922 (Address) 7522 Rockwood

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge DATE OF BURIAL, Mar 23 1922

20-UNDERTAKER, A. S. Marshall ADDRESS, 3539 Fell Road



CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62668

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 62668

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2445 St. Paul St.,

ST. 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aaron Rudo

(Residence in Baltimore: No. 305 E. 25th St.,

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, Single  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

7-AGE,

18

Yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Store Keeper 019

(b) General nature of industry, business, or establishment in which employed (or employer).

Confectioner

9-BIRTHPLACE,

(State or Country),

Balto., Md

10-NAME OF FATHER,

Bernard Rudo

11-BIRTHPLACE OF FATHER

(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Yetta Silverman

13-BIRTHPLACE OF MOTHER

(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

15-

Filed...

MAR 22 1922

ROBERT R. KRAUTER,

Bureau Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Nov

21

1922

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, that I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Coronary Disease of heart

CONTRIBUTORY

(Secondary)

(Signed)

Wm. H. H. M. D.

(Coroner)

Mar 22 1922 (Address) 732 N. Bond St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Green Washington Park

2-22-1922

20-UNDERTAKER

ADDRESS

Jack Lewis

1429 E. Calhoun

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1560 Bks.

D 62669

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2440 Fleet ST., 1 WARD)

2-FULL NAME

Augusta Hermann

(a) RESIDENCE NO.

2440 Fleet

ST., 1 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of

Martin Hermann

6 DATE OF BIRTH (month, day, and year)

Jan. 24, 1852

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

70

1

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Wilhelm Kroschke

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Wilhelmina Clayfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant

Ullrich Beuerungen

(Address)

2440 Fleet St.

15

MAR 22 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 20 1922

17

I HEREBY CERTIFY, That I attended deceased from March 4, 1922, to March 19, 1922.

that I last saw her alive on March 19, 1922.

and that death occurred, on the date stated above, at 1:10 a. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage -

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

Coma -

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

✓

Did an operation precede death? 40 Date of

Was there an autopsy? 20

What test confirmed diagnosis? usual

(Signed) Dr. R. R. Krauter, M. D.

(Address) 125 Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Immanuel Cemetery

Mch 22 1922

20 UNDERTAKER

Lilly & Ziehl

ADDRESS

4033 Maple

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62670 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62670

CERTIFICATE OF DEATH.

1-PLACE OF DEATH  
City of BALTIMORE: (No. 62670-Ann St. 91-2 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
2-FULL NAME... Autow Tash  
(Residence in Baltimore: No. 62670-Ann St. 91-2 yrs. 10 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male  
4-COLOR OR RACE, White  
5-Single, Married, Widowed, or Divorced, (Write the word.) Single  
6-DATE OF BIRTH, July 4, 1838  
7-AGE, 83 yrs. 8 mos. 15 ds.  
8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, Retired  
(b) General nature of industry, business, or establishment in which employed (or employer), Sailor U.S.A.

9-BIRTHPLACE, (State or Country), California

10-NAME OF FATHER, Unknown  
11-BIRTHPLACE OF FATHER, (State or Country), Unknown  
12-MAIDEN NAME OF MOTHER, Unknown  
13-BIRTHPLACE OF MOTHER, (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant), Anna Kolt  
(Address), 1525 Bank St.

15-  
Filed MAR 22 1922 ROBERT R. KRAUTER, Registrar.  
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 19 22  
(Month) (Day) (Year)  
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy or inquiry.) Inquiry  
thereon and from the evidence obtained by said... (Inquest, autopsy or inquiry.) Inquiry  
and that said deceased came to death on the day stated above.  
The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis  
CONTRIBUTOR (Secondary), Sclerosis  
(Signed), Geo. Chupin Brady, D.  
Mar 22 1922 (Address), 14376 Broadway

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).  
At place of death... yrs... mos... ds. In the State... yrs... mos... ds.  
Where was disease contracted, if not at place of death?

Former or usual residence...  
19-PLACE OF BURIAL OR REMOVAL, National Cemetery  
DATE OF BURIAL, Mar 22 1922  
20-UNDERTAKER, Lilly & Zeller  
ADDRESS, 4038 W. 1st St.

Physicians should state EXACTLY, PHYSICIANS should state EXACTLY, Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62671

## CERTIFICATE OF DEATH.

74-001 D 62671

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 801 N. Washington ST., 7 WARD)

### 2-FULL NAME

(a) RESIDENCE NO. 801 N. Washington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

How long in U. S., if of foreign birth? 50 yrs. mos. ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced

(or) WIFE of

August L. Korman

6 DATE OF BIRTH (month, day, and year)

April 18 1846

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

75

11

1

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Konrad Einschmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Elizabeth Bender

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Miss Nellie Korman 801 N. Washington

15

MAR 22 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 19 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 9 1922 to March 19 1922

that I last saw him alive on March 19 1922

and that death occurred, on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis

CONTRIBUTORY (Secondary)

(duration)

ys.

mos.

ds.

(duration)

ys.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward L. Cook, M. D.

(Address) 413 N. Washington

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Baltimore Cemetery

March 22 1922

20 UNDERTAKER

ADDRESS

Wm. H. Hartley

2384 Jefferson St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62672

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *Mount Hope Retreat* ST. *28<sup>th</sup>* WARD)2-FULL NAME *Harrison Gray Otis -*(a) RESIDENCE. NO. *Mount Hope Retreat* ST. *28* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *2* mos. *7*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct 10 - 1889*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*32**0**0*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Ship Building*

(b) General nature of industry, business, or establishment in which employed (or employer)

*11*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Stewart N. J.*

10 NAME OF FATHER

*H. Gray Otis*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Boston Mass*

12 MAIDEN NAME OF MOTHER

*Ellie Greer*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore Md*

14

Informant (Address)

*Records of Mt Hope Retreat Mt Hope Ma.*

15

File

*MAR 22 1922**ROBERT R. KRAUTER, Registrar**Burial Permit State*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 20 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 13<sup>th</sup> 1922, to March 20, 1922,*that I last saw him alive on *March 20, 1922,*and that death occurred, on the date stated above, at *7:15 P* m.

The CAUSE OF DEATH\* was as follows:

*Parasitis -**over**abs*(duration) *6* yrs. *0* mos. *0* ds.

CONTRIBUTORY (Secondary)

*Paranoia*(duration) *Life* yrs. mos. ds.18 Where was disease contracted If not at place of death? *Baltimore*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Frank J. Flannery* M. D.19 (Address) *Mt Hope Retreat*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Lorraine Cemetery**Mar 23 1922*

20 UNDERTAKER

ADDRESS

*H. E. Hughes 424 N. Broadway.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Primary luetic  
infection*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62673

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *525 N. East Ave* ST. *76* WARD)

## 2-FULL NAME

*Evelyn M. Kahl*

## (a) RESIDENCE

No. *525 N. East Ave*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

*1* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*F*

4 COLOR OR RACE

*W*

5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*July 12 1922*

6 DATE OF BIRTH (month, day, and year)

*July 12 1914*

7 AGE

*2* Years

Months

*8*

Days

*31*

If LESS than

1 day, hrs.

or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore*

10 NAME OF FATHER

*Arthur A. Kahl*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Baltimore*

12 MAIDEN NAME OF MOTHER

*Brenda K. Kahl*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Baltimore*

14

Informant

*Arthur A. Kahl*

(Address)

*525 N. East Ave*

15

MAR 22 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3-20*

1922

17

I HEREBY CERTIFY, That I attended deceased from

*March 12 1922*to *March 19 1922*

that I last saw her alive on

*3-19*

1922

and that death occurred, on the date stated above, at

*1 A*

m.

The CAUSE OF DEATH\* was as follows:

*Bronchial Pneumonia*

(duration)

yrs.

mos.

ds.

## CONTRIBUTORY

(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death?

*unknown*

Did an operation precede death?

*No*

Date of

Was there an autopsy?

*No*

What test confirmed diagnosis?

*pyoderma*

(Signed)

1922

(Address)

*800 N. Pitt St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*London Park*

DATE OF BURIAL

*Mar 22 1922*

20 UNDERTAKER

*Geo J. Smith*

ADDRESS

*1000**R. Fayall 4*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior*



D 62674

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 D 62674

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 736 N. Eutam St.; 11 WARD)

## REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Margaret C. Duwall

(Residence in Baltimore: No. 736 N. Eutam St.; 20 yrs., mos., ds.)

St.; 20 yrs., mos., ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

F

## 4-COLOR OR RACE

W

5-SINGLE, *Widowed*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH

Nov 9

(Month)

(Day)

(Year)

## 7-AGE

74 yrs., 4 mos., 12 ds.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9-BIRTHPLACE

(State or Country)

Baltimore City

## 10-NAME OF FATHER

Leonard C. Mettee

## 11-BIRTHPLACE OF FATHER

(State or Country)

Baltimore City

## 12-MAIDEN NAME OF MOTHER

Margaret J. Ely

## 13-BIRTHPLACE OF MOTHER

(State or Country)

Baltimore City

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Addie B. Mettee

(Address)

736 N. Eutam St.

## 15-

MAR 22 1922

ROBERT R. KRAUTER,

Burial Permit Registrar

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

March 21<sup>st</sup>

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Dec 15<sup>th</sup> 1921, to March 21<sup>st</sup> 1922,that I saw her alive on March 21<sup>st</sup> 1922,

and that death occurred, on the date stated above, at 1:45 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

(Duration) 3 yrs., mos., ds.

## CONTRIBUTORY (Secondary)

(Duration) 3 yrs., mos., ds.

(Signed) *Heber J. Williams* M. D.

March 22, 1922 (Address) 1227 N. Lafayette St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Greenmount Cemetery

Mar. 22, 1922

## 20-UNDERTAKER

## ADDRESS

George J. Smith

1000 B. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62675

## CERTIFICATE OF DEATH.

90 D 62675

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5427. Fulton Ave. ST.; 20 WARD)

## REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Ewald Wattencheidt

(Residence in Baltimore: No. 5427. Fulton Ave

St.; 67 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE,

White

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Married

## 6-DATE OF BIRTH,

Jan. 9, 1872  
(Month) (Day) (Year)

## 7-AGE,

80 yrs., 2 mos., 12 ds.

## If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Clock &amp; Watch Maker

9-BIRTHPLACE,  
(State or Country),

Germany

## 10-NAME OF FATHER,

August Wattencheidt

11-BIRTHPLACE OF FATHER  
(State or Country),

Germany

## 12-MAIDEN NAME OF MOTHER

Emilia Von Pelzer

13-BIRTHPLACE OF MOTHER  
(State or Country),

Germany

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Ewald Wattencheidt, Jr.

(Address)

5427. N. Fulton Ave

## 15-

MAR 22 1922

ROBERT R. KRAUTER,

Filed

191

Burial Permit

Register

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

March 21, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

March 6, 1922, to March 20, 1922.

that I saw him alive on March 20, 1922.

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:

Cerebral thrombosis  
Arterio-sclerosis

(Duration) 3 yrs., mos., ds.

CONTRIBUTORY  
(Secondary)

Myocardial insufficiency

(Signed)

March 21, 1922 (Address) 712 Park Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Woodlawn Cem.

## DATE OF BURIAL,

Mar 22, 1922

## 20-UNDERTAKER

Chas. E. Branch

## ADDRESS

827 Madison Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

712 Park Ave

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 62676

HEALTH DEPARTMENT—CITY OF BALTIMORE

62676

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3014 Baker ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Phila Pa

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

1. mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan - 12 - 1847

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

75

2

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Joe. Mary

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Anna Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

August Weber  
3014 Baker St

15

MAR 22 1922

ROBERT R. KRAUTER  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 20 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 19, 1922, to Mar 20, 1922

that I last saw is alive on Mar 14, 1922.

and that death occurred, on the date stated above, at 845 a.m.

The CAUSE OF DEATH\* was as follows:

carcinoma of intestine

(duration)

yrs. 6 mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Philadelphia

Did an operation precede death? no Date of x

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) V. Kim Williams, M. D.

, 19 (Address) 601 Carrollton

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St Petre. Berna. Phila

DATE OF BURIAL

3-22-22

20 UNDERTAKER

H. B. Vannoy, Soc N. S. Schrag

D 62677

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62677

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Nursery Childs Hosp* WARD)

## 2-FULL NAME

*William E. Gaffney*(a) RESIDENCE, NO. *937 W. Lombard* ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

16 mos. 9

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*M.*

4 COLOR OR RACE

*N.*5 Single, Married, Widowed,  
or Divorced (write the word)*Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Nov 12 - 1920*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*1**4**9*

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Child*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Balti. Md.*

10 NAME OF FATHER

*Wm. Gaffney*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Balti. Md.*

12 MAIDEN NAME OF MOTHER

*Elsie Gruntham*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Balti.*

14

Informant  
(Address)*Mr. William Gaffney  
937 W. Lombard St.*

15

Filed

MAR 22 1922

ROBERT R. KRASTER

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Mar. 21 1922*

17

I HEREBY CERTIFY, that I attended deceased from  
*Mar 15. 1922* *Mar. 21 1922*  
that I last saw him alive on *Mar 21 1922*  
and that death occurred, on the date stated above, at *11 a m.*

The CAUSE OF DEATH\* was as follows:

*Broncho Pneumonia*CONTRIBUTORY  
(Secondary)*1 day*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Wm. Gaffney*  
*207 E. Pratt St.*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Calhoun Cem.* *Mar 22 1922*

20 UNDERTAKER

ADDRESS

*John J. Cowan* *207 E. Pratt St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 62678

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 62678

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1913 Sherwood Ave. 9 WARD)

2-FULL NAME Mary Snyder

(a) RESIDENCE NO. 1913 Sherwood Ave. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 6 1918

7 AGE Years 4 Months 2 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) MD.

10 NAME OF FATHER Julius Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) MD.

12 MAIDEN NAME OF MOTHER Mary Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) MD.

14 Informant Mrs. Mary Snyder (Address) 1913 Sherwood Ave.

15 MAR 22 1922 ROBERT R. KRAUTER, Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar. 14, 1922 to Mar. 20, 1922, that I last saw her live on Mar. 20, 1922, and that death occurred, on the date stated above, at 7:00 p. m. The CAUSE OF DEATH\* was as follows:

Measles

(duration) yrs. mos. 14 ds.

CONTRIBUTORY Broncho-Pneumonia (Secondary)

(duration) yrs. mos. > ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? 1. Suppurative

(Signed) J. E. Brumbaugh M. D.

4-24-1922 (Address) 1531 E. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral Cemetery Mar. 27 1922

20 UNDERTAKER

George J. Ruth 1735 Hayford

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 62679 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62679

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 S. East Ave 1 ST. WARD)

2. FULL NAME Chas. H. J. Miller

(a) RESIDENCE No. 22 S. East Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of Elizabeth W. Miller (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 25 - 81

7 AGE Years 40 Months 9 Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing

(b) General nature of industry, business, or establishment in which employed (or employer) Sewter

(c) Name of employer

9 BIRTHPLACE (city or town) City (State or country)

10 NAME OF FATHER Henry Miller

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Helena

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Elizabeth W. Miller (Address) 22 S. East Ave

15 MAR 22 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/20 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4 1922 to Mar 20 1922, that I last saw him alive on Mar 20 1922, and that death occurred, on the date stated above, at 3:35 P. m.

The CAUSE OF DEATH\* was as follows:

Lav. Tuberculosis (duration) yrs. 16 mos. ds.

CONTRIBUTORY (Secondary) P. R. Austin (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Examination met Dr. G. B. Blades (Signed) 143 76 3 May M. D. 19 (Address) G. B. Blades

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL 3/23 1922

20 UNDERTAKER Philip Hennig ADDRESS 2016 Orleans

Spec. -1-10-21-M&T-1500 Bks.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 62680

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 62680

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 430 N. Luzerne Ave. ST. 6 WARD)

2-FULL NAME

Edward F. Green

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

430 N. Luzerne Ave.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

42 yrs. 10 mos. 28 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

~~WIFE of~~

Irene Green

6 DATE OF BIRTH (month, day, and year)

Apr 22-79

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

42

10

28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Lent. Fire

(b) General nature of industry, business, or establishment in which employed (or employer)

Dept

(c) Name of employer

retired

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

John Green

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Sarah M.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Irene Green  
430 N. Luzerne Ave.

15

MAR 22 1922

ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/20 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 13, 1922 to March 20, 1922

that I last saw him live on 11 20 1922

and that death occurred, on the date stated above, at 10:20 P. m.

The CAUSE OF DEATH\* was as follows:

Valvular heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. Q. Deaver, M. D.

3/21, 1922 (Address) 2600 E. Baltimore

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Oak Lawn

DATE OF BURIAL

3/23, 1922

20 UNDERTAKER

Philip Henwig

ADDRESS

2016

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62681

## CERTIFICATE OF DEATH.

144D 62681

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2106 Paul Road* St.; *25* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *2106 Paul Road* St.; *25* WARD) yrs., 1 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Female.*

## 4-COLOR OR RACE,

*White*

## 5-SINGLE,

*Married*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH.

*June**10*, 19*26*  
(Month) (Day) (Year)

## 7-AGE.

*35**9* mos. ds.If LESS than 1 day,  
...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*Housewife*  
*037*9-BIRTHPLACE,  
(State or Country),

## 10-NAME OF FATHER,

*John O'Neil*11-BIRTHPLACE OF FATHER  
(State or Country),*Pa.*

## 12-MAIDEN NAME OF MOTHER

*Marynet Richards*13-BIRTHPLACE OF MOTHER  
(State or Country),*Pa.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

Filed

MAR 22 1922

ROBERT R. KRAUTER,

Baltimore, Md.

ROBERT R. KRAUTER

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*March* *20*, 19*22*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*March 20* 19*22*, to *March 20* 19*22*,that I saw him live on *March 20* 19*22*,and that death occurred, on the date stated above, at *5 P.* m.

The CAUSE OF DEATH\* was as follows:

*Coronary*(Duration) *7* mos. ds.CONTRIBUTORY (Secondary) *Internal Hemorrhage*(Duration) *10* yrs. *10* mos. *10* ds.(Signed) *Raymond J. ...* M. D.*March 22* 19*22* (Address) *Lakeland*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Landon Park*

## DATE OF BURIAL,

*March 23* 19*22*

## 20-UNDERTAKER

*George J. Smith*

## ADDRESS

*1000 ...*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62682

## CERTIFICATE OF DEATH.

D 62682

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 North Payson

ST., 20 WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

Regina M. Phelps

### (a) RESIDENCE NO.

21 North Payson

ST., WARD

(Usual place of abode) Length of residence in city or town where death occurred 74 yrs. 4 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James G. Phelps

6 DATE OF BIRTH (month, day, and year) Sept. 6 1847

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 74 4 15

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Maryland (State or country)

10 NAME OF FATHER Joseph B. Thompson

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Levinia E. Little

13 BIRTHPLACE OF MOTHER (city or town) Pa (State or country)

14 Informant Mrs. May L. Prevost (Address) 21 North Payson St.

15 Filed MAR 22 1922 ROBERT R. KRAUTER, Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 22 to March 20, 1922

that I last saw her alive on March 20, 1922 and that death occurred, on the date stated above, at 3.30 A. M.

The CAUSE OF DEATH was as follows: Corenomia of Liver

(duration) yrs. mos. ds.

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? (Signed) M. D.

(Address) 547 Fulton

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

### 19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral Cemetery.

### 20 UNDERTAKER

Joseph B. Cook

### DATE OF BURIAL

March 21 1922

### ADDRESS

1003 N. Baltimore St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62683

D 62683 CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1731 Bolton St.

ST.: 14 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Louie Saupp

## (a) RESIDENCE. NO.

1731 Bolton St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 2

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Aug. 23<sup>rd</sup> 1841

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

81

6

21

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Bedford Pa.

## 10 NAME OF FATHER

Andrew Saupp

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Agnes Keller

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

## 14

Informant

Mrs. Emma E. Gould

(Address)

1731 Bolton St.

MAR 22 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 21<sup>st</sup> 1922

## 17

I HEREBY CERTIFY That deceased from Mar. 19, 1922, to Mar. 21, 1922, that I last saw him alive on Mar. 21, 1922,

and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH\* was as follows:

Apoplexy

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Cardiac Asthenia

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

at place of death

## Did an operation precede death?

No

## Was there an autopsy?

No

## What test confirmed diagnosis?

Physical signs

(Signed)

Mar. 22<sup>nd</sup>

(Address)

1901 Eutan Place  
\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Bedford Pa

## DATE OF BURIAL

3/28/22

## 20 UNDERTAKER

Joe B. Cook

## ADDRESS

1403 W. Baltimore

D 62684

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62684

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2106 Paul Road ST.; 25 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 2106 Paul Road at Mt. Vernon St.; yrs., mos., ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Infant

## 6-DATE OF BIRTH

March 20, 1912  
(Month) (Day) (Year)

## 7-AGE,

no

yr.

mo.

da.

If LESS than 1 day,

6 hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE, (State or Country),

Baltimore

## PARENTS.

## 10-NAME OF FATHER,

R. H. H. Ridgway

## 11-BIRTHPLACE OF FATHER (State or Country),

Baltimore

## 12-MAIDEN NAME OF MOTHER

Maggie L. Richardson

## 13-BIRTHPLACE OF MOTHER (State or Country),

Va

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

R. H. H. Ridgway

(Address)

Mt. Vernon

MAR 22 1922

ROBERT R. KRAUTER,

Filed

191

Burial Permit

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

March 20, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

March 20, 1922, to March 20, 1922,

that I saw him on March 20, 1922,

and that death occurred, on the date stated above, at 9:40 p.m.

The CAUSE OF DEATH\* was as follows:

Still Birth  
Pneumonia  
(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

March 22, 1922 (Address) L. H. H. H.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Landon Park

## DATE OF BURIAL,

Mar. 23, 1922

## 20-UNDERTAKER

George J. Smith

## ADDRESS

Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62685

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 W. Hamburg ST.; 23 WARD)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Baby Tudor

(Residence in Baltimore: No. 122 W. Hamburg St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *W* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*  
(Write the word.)

6-DATE OF BIRTH. *March 20, 1922*  
(Month) (Day) (Year)

7-AGE. *Less than 1 day*  
yrs. mos. ds. hrs. or min.

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *Infant*  
(b) General nature of industry, business, or establishment in which employed (or employer). *OTO*

9-BIRTHPLACE. *Baltimore Md*  
(State or Country),

10-NAME OF FATHER. *William Leonard Tudor*  
11-BIRTHPLACE OF FATHER. *Md*  
(State or Country),  
12-MAIDEN NAME OF MOTHER. *Fannie Elizabeth Miller*  
13-BIRTHPLACE OF MOTHER. *Md*  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William W. Sparks*(Address) *S. Baltimore Ave*

15-

MAR 22 1922

Filed

ROBERT R. KRAUTER, Registrar.

Burial Permit

19033

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *March 20, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *March 20 1922*, to *March 20 1922*, that I saw him alive on *March 20 1922*, and that death occurred, on the date stated above, at *3:58 P m.* The CAUSE OF DEATH\* was as follows:

*Asphyxiation*  
*Congenital Malformation*  
*of Skull & Brain*  
(Duration) yrs. mos. ds.

CONTRIBUTORY. (Secondary)

(Signed) *Susan R. Parsons M. D.*  
*3-20-22* (Address) *The Arsenal*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. *Carnegie Mortuary of Embury & Co*

DATE OF BURIAL.

....., 191...

20-UNDERTAKER

ADDRESS

MAR 2 1922



## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 62686

## CERTIFICATE OF DEATH.

90 D 62686

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2111 Longwood

ST. 15 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Wilhelmina Emma Moog*

(a) RESIDENCE, No. 2111 Longwood

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? 72 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Berman Moog*

6 DATE OF BIRTH (month, day, and year) Apr 19, 1839

7 AGE Years 82 Months 11 Days 1 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House Work*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *Emm*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Emm*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*14 Informant *Berman Moog Jr.* (Address) *2111 Longwood St.*

15 MAR 22 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1922

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1922, to March 20, 1922, that I last saw her alive on March 20, 1922, and that death occurred, on the date stated above, at 7:45 P. M.

The CAUSE OF DEATH\* was as follows: *Chr. Endo. Carditis with mitral + Aortic regurgitation (Arterio-sclerosis)*(duration) *Several* yrs. mos. ds.CONTRIBUTORY (Secondary) *Asthma - Anuria 3 days.**Exhaustion* (duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? ☒Did an operation precede death? *no* Date of ☒Was there an autopsy? *no*What test confirmed diagnosis? *Clinical Ex and*(Signed) *Robert W. Miffelin* M. D.19 (Address) *1016 Madison St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*London Park Cem* *Mar 20 1922*

20 UNDERTAKER ADDRESS

*E. Schlonman & Son* *1529*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62687

## CERTIFICATE OF DEATH.

31 D 62687

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1913 Longwood ST. 15 WARD)

2-FULL NAME Rachel Elizabeth Luter

(a) RESIDENCE NO. 1913 Longwood  
(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 17 yrs. 3 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 7 1904

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
17 3 16

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country)

10 NAME OF FATHER Mr. E. Luter

11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country)

12 MAIDEN NAME OF MOTHER Rachel Strain

13 BIRTHPLACE OF MOTHER (city or town) Del  
(State or country)

14 Informant Mr. Rachel Luter  
(Address) 1913 Longwood St

15 MAR 22 1922 ROBERT R. KRAUTER,  
Burial Permit Center

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 19 22

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 19 22, to Mar 21, 19 22, that I last saw him alive on Mar 20, 19 22, and that death occurred, on the date stated above, at 10 a. m. The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. — mos. — ds.

### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) John J. Talbot, M. D.

19 (Address) 1353 W North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cranbury Cemetery

March 23 1922

20 UNDERTAKER

ADDRESS

W. M. Koutson

2238 N North

D 62688 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62688

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4504 Springdale Ave. ST. 28 WARD)

## 2. FULL NAME

Doris Raughley Porter

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

4504 Springdale Ave. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year) Dec 19 1915

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
5 3 2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Lyman Porter

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md Lawrence

12 MAIDEN NAME OF MOTHER

Helen Ernst

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

Walter C Bacon  
100 E 20th St

15

MAR 22 1922

ROBERT R. KRAUTER,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 6 1922, to March 21 1922, that I last saw her alive on March 20 1922,

and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH\* was as follows:

Acute Endo Carditis

(duration) yrs. 2 mos 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Throat of disease

(Signed) Walter C Bacon M. D.

3/22/1922 (Address) 100 E 20th St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park Cemetery March 24 1922

20 UNDERTAKER

W M Routson

ADDRESS

2238 N. North

PHYSICIANS should state EXACTLY, AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No further history.*



Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 D 62689

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ST., WARD)

JOHNS HOPKINS HOSPITAL

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

Willie Anthony Mills

### (a) RESIDENCE NO.

308 N. Pine

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

unknown mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

#### 3 SEX

Male

#### 4 COLOR OR RACE

Colored

#### 5 Single, Married, Widowed, or Divorced, (write the word)

Single

#### 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

#### 6 DATE OF BIRTH (month, day, and year)

Dec. 10 1919

#### 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

3

8

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Child

### 9 BIRTHPLACE (city or town) (State or country)

#### 10 NAME OF FATHER

Williean Mills

#### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

#### 12 MAIDEN NAME OF MOTHER

N.C. Josephine Allston

#### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

N.C.

#### 14

Informant (Address)

JOHNS HOPKINS HOSPITAL

#### 15

MAR 22 1922

ROBERT K. KRAUTER,

Registrar

### MEDICAL CERTIFICATE OF DEATH

#### 16 DATE OF DEATH (month, day, and year)

March 18, 1922

#### 17

I HEREBY CERTIFY, That I attended deceased from Feb 10, 1922 to March 18, 1922, that I last saw him alive on March 18, 1922, and that death occurred, on the date stated above, at 11:15 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis -

(duration)

yrs.

mos.

ds.

#### CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

#### 18 Where was disease contracted if not at place of death?

Home

Did an operation precede death?

no

Date of

Was there an autopsy?

What test confirmed diagnosis?

X-Ray & tuberculin test

(Signed) Horace G. Stewart, M. D.

3/19/22 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

#### 19 PLACE OF BURIAL, CREMATION OR RE-

#### DATE OF BURIAL

ROYAL Mt auburn

Mar 22 1922

#### 20 UNDERTAKER

#### ADDRESS

R. B. Gross / 1405 M. E. L. Ave.

D 62690 HEALTH DEPARTMENT—CITY OF BALTIMORE 62690

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2929 Westwood St. 15 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Elizabeth Buchheimer

## (a) RESIDENCE. NO.

2929 Westwood St.

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

63

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced (write the word)

Female White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Sept. 17, 1858

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

63

6

5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

## 10 NAME OF FATHER

Geo. H. Buchheimer

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Mary Buchheimer

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

## 14

Informant (Address)

Barbara Sencaster 2922 W North Ave

## 15

Filed

Robert F. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) MAR 22 1922

## 17

I HEREBY CERTIFY, That I attended deceased from Mar. 13<sup>th</sup> 1922, to Mar. 21, 1922, that I last saw her alive on Mar. 21-1922, and that death occurred, on the date stated above, at 8. a. m. The CAUSE OF DEATH\* was as follows:

Bronchopneumonia.

(duration) yrs. mos. 9 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Oscar E. Dickson, M. D.

MAR 22 1922 (Address) 3055 N. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Baltimore

MAR 24 1922

## 20 UNDERTAKER

## ADDRESS

Geo W Little

2700 Edmondson Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of UPA-TION is very important. See instructions on back of certificates.

MAR 22 1922

D 62691

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62691

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3820 Halle Road)

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 3820 Halle Road

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

White

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

married

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

7-AGE,

68

yrs.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Builder 075

(b) General nature of industry, business, or establishment in which employed (or employer).

Stone mason

9-BIRTHPLACE,

(State or Country).

Baltimore

10-NAME OF FATHER,

William Boone

11-BIRTHPLACE OF FATHER (State or Country).

Ireland

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country).

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Curroll Boone

(Address)

3820 Halle Road

15-

Robert P. Harrison,

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Mar 20, 1922

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, and inquired thereon and from the evidence obtained by said inquest, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Coronary disease of heart

CONTRIBUTORY (Secondary)

(Signed) J. H. Harrison, M.D. (Coroner)

Address 7632 W. 11th St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

Cathedral

DATE OF BURIAL,

March 21, 1922

20-UNDERTAKER

Martin P. Hays

ADDRESS

1837 W. North

Important. See instructions on back of certificate.

D 62692

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 N Broadway ST.; 6 WARD)

## 2-FULL NAME

Baby Bernman(a) RESIDENCE. No. 15 N Broadway ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

male white single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 21, 1922

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or Min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltmd

10 NAME OF FATHER

Abraham Bernman11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Russia

12 MAIDEN NAME OF MOTHER

Fannie Ros13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Russia

14

Informant  
(Address)Dr. F. Bernman  
2631 N Calvert St

15

Filed

Robert P. Hartman

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21, 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 21, 1922 to March 21, 1922that I last saw him alive on March 21, 1922and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH\* was as follows:

Asphyxia neonatorum(duration) yrs. 30 min.CONTRIBUTORY  
(Secondary)Birth Asphyxia(duration) yrs. 6 hrs.18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Phys. signs(Signed) Dr. F. Bernman M. D., 19 (Address) 2631 N Calvert St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Luke's Hospital, New York 3-22-22

20 UNDERTAKER

ADDRESS

Jack Lewis, 1439 Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

R 2 1922

Burial Permit Clerk



## HEALTH DEPARTMENT—CITY OF BALTIMORE 62693

D 62693

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE No.

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,

or Divorced, (write the word)

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

MAR 22 1922

Registrar

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

WARD)

WARD

(If non-resident give city or town and State)

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, that I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1916 62694

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

131 D 62694

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Frederick Kalthoff

(a) RESIDENCE No.

309 S. Collington Ave.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

unknown yrs. 0 mos. 0 ds.

How long in U. S., if of foreign birth?

yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

~~WIFE of~~

Catharine Kalthoff

6 DATE OF BIRTH (month, day, and year)

Feb. 18<sup>th</sup> 1875

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

47

1

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Glass maker

(b) General nature of industry, business, or establishment in which employed (or employer)

017

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Frederick Kalthoff

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Annella Bonn

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

Records

15

Robert P. Harrison

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 26<sup>th</sup>, 1921, to March 22, 1922, that I last saw him alive on March 21, 1922, and that death occurred, on the date stated above, at 9:30 p. m.

The CAUSE OF DEATH\* was as follows:

Pericarditis

(duration) 3 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary)

Bronchopneumonia (duration) yrs. 0 mos. 3 ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

Blood exam, Urine culture.

(Signed) John F. Dorsey, M. D.

, 19 (Address) T. H. H.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Thomas M. C. C. C.

DATE OF BURIAL

March 24 1922

20 UNDERTAKER

Louis Heemann

ADDRESS

325 B. W. Ave.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

D 62695

CERTIFICATE OF DEATH

101-001

D 62695

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1701 Madison Ave

St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME George H. House

(Residence in Baltimore: No. 1701 Madison Ave

St. 45 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Divorced (Write the word)

16 DATE OF DEATH March 22, 1922 (Month) (Day) (Year)

6 DATE OF BIRTH Sep 8, 1872 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1922, to March 22, 1922.

7 AGE 47 yrs. 6 mos. 14 ds. or less than 1 day, hrs. or min.?

that I saw him alive on March 22, 1922, and that death occurred, on the date stated above, at 4:50 P.M. The CAUSE OF DEATH\* was as follows:

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Stock Broker

Pulmonary Edema (Duration) yrs. mos. ds.

9 BIRTHPLACE (State or country) Wash. D.C.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

10 NAME OF FATHER Samuel A. House

(Signed) H. Caspary M. D. (Address) 1603 Madison Ave

11 BIRTHPLACE OF FATHER (State or country) Maryland

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

12 MAIDEN NAME OF MOTHER Mary E. Sullivan

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

13 BIRTHPLACE OF MOTHER (State or country) Maryland

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter S. House

(Address) Brown Head Run, 1728 N. W.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Druid Ridge Cemetery March 24, 1922

20 UNDERTAKER ADDRESS

John C. Crichtell, 2011 Tray St.

15

Robert E. Harrison, 191

REGISTRAR

22 2 1922

DEPT. OF HEALTH

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62696

## CERTIFICATE OF DEATH.

179 D 62696

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

905 N. Charles

ST.

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Harriet Josephine Shearer

(a) RESIDENCE. NO.

905 N. Charles

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

50

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Dr. Thomas Shearer

6 DATE OF BIRTH (month, day, and year)

Feb. 22, 1834

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

88

1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Philadelphia

10 NAME OF FATHER

George Fox

11 BIRTHPLACE OF FATHER (city or town)

Phila Pa

(State or country)

12 MAIDEN NAME OF MOTHER

Mary Butler

13 BIRTHPLACE OF MOTHER (city or town)

England

(State or country)

14

Informant

Thomas L. Shearer

(Address)

905 N. Charles St

15

Filed

Robert P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20, 1922

17

I HEREBY CERTIFY, That I attended deceased from

January, 1922, to March 20, 1922.

that I last saw her alive on March 20, 1922.

and that death occurred, on the date stated above, at 1:15 P. M.

The CAUSE OF DEATH\* was as follows:

CHRONIC INTERSTITIAL NEPHRITIS

(duration) 5 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Always lived at home.

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas L. Shearer, M. D.

(Address) 905 N. Charles St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Landon Park

DATE OF BURIAL

3-28 19

20 UNDERTAKER

Henry J. Gustin &amp; Sons

ADDRESS

2700 N. Charles St

Archard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

222 1922

Burial Permit Clerk.



Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62697

## CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1000 N. Wolfe* St. *7*)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *William L. Duall*

(Residence in Baltimore: No. *1000 N. Wolfe* St.; yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX <i>Male</i>	4-COLOR OR RACE <i>Col.</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <i>Single</i> (Write the word.)
6-DATE OF BIRTH, <i>Oct. 12, 1919</i> (Month) (Day) (Year)		
7-AGE, <i>2</i> yrs. mos. ds. If LESS than 1 day, ...hrs. or ...min.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>Bar.</i> (b) General nature of industry, business, or establishment in which employed (or employer). <i>000</i>		
9-BIRTHPLACE. (State or Country). <i>Balt.</i>		
PARENTS.	10-NAME OF FATHER, <i>William L. Duall</i>	
	11-BIRTHPLACE OF FATHER (State or Country). <i>Balt.</i>	
	12-MAIDEN NAME OF MOTHER, <i>Edith Gettridge</i>	
	13-BIRTHPLACE OF MOTHER (State or Country). <i>Balt.</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address) *1000 N. Wolfe*

15-

Robert P. Harrison,

191

Burial Permit Clerk. Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 20, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Pneumonia*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Wm. L. Duall*

(Coroner)

*3-21, 1912* (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Evergreen Cem. April 23, 1922*

20-UNDERTAKER

ADDRESS

*Mrs. J. G. Locks 1302 Jefferson*

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62698

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62698

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Bay View Hospital 3* St. *3* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

*Hertford, Hale, Leonard & Ester*

(Residence in Baltimore: No. .... St.; yrs. .... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *M* 4-COLOR OR RACE, *W* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Single*

6-DATE OF BIRTH, (Month) (Day) (Year) *1*

7-AGE, *32* yrs. .... mos. .... ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Police Officer* (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country) *Nebraska*

PARENTS: 10-NAME OF FATHER, 11-BIRTHPLACE OF FATHER, (State or Country), 12-MAIDEN NAME OF MOTHER, 13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) *Bay View Hospital* (Address) .....

15- Robert P. Harrison, 1922 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Mar 20* 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Inquiry* find that said deceased came to *his* death (Inquest, autopsy or inquiry.) on the day stated above. The CAUSE OF DEATH\* was as follows:

*Acute Alcoholism -* (Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY *Exhaustion* (Secondary) (Duration) .... yrs. .... mos. .... ds. (Signed) *Robert P. Harrison* M. D. (Address) *14376 Brady*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, institutions, Transients, or Recent Residents). At place of death, .... yrs. .... mos. .... ds. In the State, .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence, .....

19-PLACE OF BURIAL OR REMOVAL, *Indianapolis Ind* DATE OF BURIAL, *Mar 22, 1922*

20-UNDERTAKER, *Wm J. Tickner* ADDRESS, *N. & Pa.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62699

## CERTIFICATE OF DEATH.

D 62699

## 1-PLACE OF DEATH .

CITY OF BALTIMORE: (No. *1807 N. Washington ST.* WARD) *8*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Kate Schanze*(a) RESIDENCE. No. *1807 N. Washington ST.* WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. *Life* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *William Schanze*

6 DATE OF BIRTH (month, day, and year)

7 AGE Years *64* Months Days *18* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Maryland* (State or country)10 NAME OF FATHER *Philip Mylberger*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)14 Informant *Edna Felling* (Address) *1807 N. Washington ST.*15 Filed *Robert P. Harrison* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 20 1922*17 I HEREBY CERTIFY, That I attended deceased from *Sept 5*, 19*21*, to *Mar 20*, 19*22*, that I last saw her alive on *Mar 20*, 19*22*, and that death occurred, on the date stated above, at *1222* A.M.

The CAUSE OF DEATH\* was as follows:

*Chronic Interstitial Nephritis*(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *D. Lloyd*, 19 (Address) *2232 Euter St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*W. London Park* *Mar 24 1922*

20 UNDERTAKER

*varian Jaffer*ADDRESS *1600 W. North Ave*

Physicians should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. Exact statement of Cause of Death in plain terms, so that it may be properly classified. See instructions on back of certificates.

22 1922

Burial Permit Clerk.

D 62700 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62700

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 E North Ave ST. 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME Mary Ella Henderson

(a) RESIDENCE. No. 810 E North Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds.

How long in U. S., If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

George M Henderson

6 DATE OF BIRTH (month, day, and year)

May 9 1870

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

51

11

11

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Philadelphia Pennsylvania

10 NAME OF FATHER

Abraham Albright

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pennsylvania

12 MAIDEN NAME OF MOTHER

Lena Vogenz Mary Ella Albright

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Philadelphia Pennsylvania

14

Informant (Address)

Geo. M. Henderson 810 E. North Ave

15

Filed

Robert P. Harrison,

19

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 21 1922

17

I HEREBY CERTIFY, That I attended deceased from March 18, 1922, to March 21, 1922, that I last saw her alive on March 20, 1922, and that death occurred, on the date stated above, at 10 A. M. The CAUSE OF DEATH\* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos. ds. 4

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

W. A. Fair, M. D.

3/21, 1922 (Address)

12 E 25th St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Peace Cem. Philadelphia

3/23 1922

20 UNDERTAKER

ADDRESS

Robert Brooks &amp; Son

Hollins

PHYSICIANS should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



D 62701

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62701

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 447 E.Lanvale

ST.: 12 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry N.Holtz, Jr.

(a) RESIDENCE. No. 447 E.Lanvale  
(Usual place of abode)

ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 16, 1921

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
5 6

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.  
(State or country)

10 NAME OF FATHER Harry N.Holtz,

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md.  
(State or country)

12 MAIDEN NAME OF MOTHER Viola h.C.Krebs,

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md.  
(State or country)14 Informant Harry N.Holtz,  
(Address) 447 E.Lanvale St

15 Filed Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAR 22 1922

17

I HEREBY CERTIFY, That I attended deceased from  
Mar 22, 1922, to Mar 22, 1922.  
that I last saw him alive on Mar 22, 1922.  
and that death occurred, on the date stated above, at 12:57 p.m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY  
(Secondary)18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Byrd, M. D.

Address 1405 EDMONDSON AVE.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Western Cem MAR 23 1922

20 UNDERTAKER

Geo W Little Edmondson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 22 1922

Burial Permit Clerk

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62702

## CERTIFICATE OF DEATH.

D 62702

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Bon Secour Hospital 15

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Thomas D. Harris, Jr.

(Residence in Baltimore: No.

4322 Park Heights Ave

St. 4 yrs., 0 mos. 22 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE,

White

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

## 6-DATE OF BIRTH,

Feb. 27, 1918

## 7-AGE,

4 yrs., 0 mos. 22 ds.

If LESS than 1 day,

...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

None

## 9-BIRTHPLACE, (State or Country),

Balto. Md.

## 10-NAME OF FATHER,

Thos. D. Harris

## 11-BIRTHPLACE OF FATHER (State or Country),

Camden. N. J.

## 12-MAIDEN NAME OF MOTHER

Lottie Shaw

## 13-BIRTHPLACE OF MOTHER (State or Country),

Balto. Md.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Thos. D. Harris, Jr.

(Address)

4322 Park Heights Ave

## 15-

Robert P. Harrison,

Filed

191

Burial Permit Clerk. Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

March 21, 1922

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

March 4, 1922, to Mar. 21, 1922,

that I saw him alive on March 21, 1922,

and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH\* was as follows:

"Hodgkin's" Disease

(Duration) One (7) yrs., 0 mos., 22 ds.

## CONTRIBUTORY (Secondary)

Secondary Anemia

(Signed) S. Lloyd Johnson, M. D.

3-21, 1922 (Address) Bon Secour Hosp.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 7 mos. 7 ds. In the State 4 yrs. 0 mos. 22 ds.

Where was disease contracted, if not at place of death? At home

Former or usual residence 4322 Park Heights Ave

## 19-PLACE OF BURIAL OR REMOVAL,

London Park

## DATE OF BURIAL,

Mar. 24, 1922

## 20-UNDERTAKER

Wm. J. Dickner &amp; Sons

## ADDRESS

N. &amp; Pa.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

D 62703

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62703

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1626 Alice Ann ST.; 2 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Thomas Vulgaris(Residence in Baltimore: No. 1626 Alice Ann St.; 2 yrs., 0 mos., 0 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE,

White

## 5-SINGLE,

Married

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

## 6-DATE OF BIRTH,

Unknown, 1887

(Month)

(Day)

(Year)

## 7-AGE,

55 yrs., 0 mos., 0 ds.

If LESS than 1 day,

....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Fireman

(b) General nature of industry, business, or establishment in which employed (or employer).

086

## 9-BIRTHPLACE,

(State or Country),

Greece

## 10-NAME OF FATHER,

Georgios Vulgaris

## 11-BIRTHPLACE OF FATHER

(State or Country),

Greece

## 12-MAIDEN NAME OF MOTHER

Maria Allgano

## 13-BIRTHPLACE OF MOTHER

(State or Country),

Greece

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Thos. Vulgaris

(Address)

1626 Alice Ann St

## 15-

Robert P. Harrison,

Filed

AR 22 1922

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Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Feb 21, 1922

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Feb 15, 1922, to Feb 21, 1922,that I saw h — alive on Feb 21, 1922,and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH\* was as follows:

Chorea M. D.

(Duration).....yrs.....mos.....ds.

## CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

1626 Alice Ann St (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL.

WoodlawnMar. 23, 1922

## 20-UNDERTAKER

## ADDRESS

Peter Nicolaus2046 Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62704

## CERTIFICATE OF DEATH.

D 62704

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 E Centre St. ST.: 4 WARD)

## 2-FULL NAME

Ella P Stevens

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE. NO.

110 E Centre St. ST.: 4 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Caucasian 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Stevens6 DATE OF BIRTH (month, day, and year) Unknown7 AGE Years 40 Months — Days — If LESS than 1 day, hrs. — or min. —

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse girl(b) General nature of industry, business, or establishment in which employed (or employer) Nurse girl(c) Name of employer Mrs. Murphy

## 9 BIRTHPLACE (city or town)

(State or country) Prince George Co10 NAME OF FATHER Unknown

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown12 MAIDEN NAME OF MOTHER Jane Grace

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Prince George Co

## 14

Informant Mr. J. Murphy  
(Address) Int-Washington Ball-C

## 15

MAR 23 1922 ROBERT R. KRAUTER  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1922

17

I HEREBY CERTIFY, That I attended deceased from January 23, 1922, to March 14, 1922, that I last saw her alive on March 14, 1922, and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH\* was as follows:

Chronic EndocarditisCONTRIBUTORY (Secondary) Acute Dilatation of Heart  
(duration) yrs. — mos. — ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Physical  
(Signed) Edw. J. Coolahan M. D.7/21, 1922 (Address) 24 N. Fulton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Catholic  
Barney Brown Co

DATE OF BURIAL

March 13, 1922

20 UNDERTAKER

Mrs. R. A. ElliottADDRESS 1725Oakland St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Physicians should state exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62705

## CERTIFICATE OF DEATH.

11-001

D 62705

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2021 Woodberry Lane*)

2-FULL NAME *Mary E. Harding*

(a) RESIDENCE NO. *2021 Woodberry Lane*

(Usual place of abode)

Length of residence in city or town where death occurred *48* yrs. *13* mos. *13* ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*

4 COLOR OR RACE *White*

5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *John A. Harding*

6 DATE OF BIRTH (month, day, and year) *March 9, 1874*

7 AGE

Years *48*

Months

Days *13*

If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Ind*

10 NAME OF FATHER *Unknown*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Unknown*

12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*

14 Informant *John A. Harding* (Address) *2021 Woodberry Lane*

15 *MAR 23 1922* ROBERT K. KRAUTER, Registrar

Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 22, 1922*

17

I HEREBY CERTIFY, That I attended deceased from *3-1-22* to *3-22-22*, 1922,

that I last saw him alive on *3-22-22*, 1922,

and that death occurred, on the date stated above, at *3 a.m.*

The CAUSE OF DEATH\* was as follows:

*Pneumonia (Bacterial)*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *No*

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Physical exam*

(Signed) *C. H. Hughes*, M. D.

*3-22-22* (Address) *3701 E. Carey*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*St. Peter's Cem March 24, 1922*

20 UNDERTAKER

ADDRESS

*Chenoweth Son Chestnut St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62706

## CERTIFICATE OF DEATH.

129 D 62706

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3548 Poole* ST. *13* WARD)2-FULL NAME *John W Lewis*(a) RESIDENCE NO. *3548 Poole*

(Usual place of abode)

Length of residence in city or town where death occurred *22* mos. *3* yrs. *29* ds.

ST.,

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male White**Widowed*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Sarah J Lewis*6 DATE OF BIRTH (month, day, and year) *Nov 26 1844*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*77**3**23*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired 046*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Cardgrinder*

(c) Name of employer

*In Cotton Hill*

9 BIRTHPLACE (city or town) (State or country)

*Ind*

10 NAME OF FATHER

*John W Lewis*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ind*

12 MAIDEN NAME OF MOTHER

*Sarah Jackson*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ind*

14

Informant (Address)

*Charles Lewis*

15

MAR 23 1922

ROBERT R. KRAUTER,

Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 21 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Week 16th, 1922, to Week 21st, 1922,*that I last saw him alive on *Week 20th, 1922,*and that death occurred, on the date stated above, at *8:00 P.M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Interstitial Nephritis*(duration) *1* yrs. *1* mos. *1* ds.

CONTRIBUTORY (Secondary)

*High blood pressure, Arteriosclerosis, Senility*(duration) *1* yrs. *1* mos. *1* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Urinary findings*(Signed) *B. G. Williams, M.D.*3/22/1922 (Address) *W 7th Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*St Marys Hospital**March 23 1922*

20 UNDERTAKER

ADDRESS

*Cohen & Sons, Baltimore*

CAUTION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 62707

HEALTH DEPARTMENT—CITY OF BALTIMORE

62707

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 Pennsylvania Ave. ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Thomas Benton Dawson

(a) RESIDENCE NO. 1022 Pennsylvania Ave.  
(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 ~~Single~~ Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of Catherine Dawson (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 27th, 1850

7 AGE Years 72 Months 1 Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Lumber Yard

(c) Name of employer Theo Mottu & Co.

9 BIRTHPLACE (city or town) Baltimore Md.  
(State or country)

10 NAME OF FATHER Charles A. Dawson

11 BIRTHPLACE OF FATHER (city or town) Balto Md.  
(State or country)

12 MAIDEN NAME OF MOTHER Annie Dillemant

13 BIRTHPLACE OF MOTHER (city or town) Penna.  
(State or country)

14 Informant Mrs Catherine Dawson  
(Address) 1022 Penna Ave.

15 MAR 23 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 21, 1922, to Mar 22, 1922, that I last saw him alive on Mar 21, 1922,

and that death occurred, on the date stated above, at 5:20 m.

The CAUSE OF DEATH\* was as follows:

Coronary Thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) William E. Burton, M. D.

, 19 (Address) 762 Dolphin

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Loudon Park Cemetery

DATE OF BURIAL

Mar 25-1922

20 UNDERTAKER

William E. Burton

ADDRESS

762 Dolphin



D 62708

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62708

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 Maryland Ave ST.: 17 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Bean Tippett(a) RESIDENCE. No. 307 Maryland Ave Westport ST. 17 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of

Maria Louise Bean  
6 DATE OF BIRTH (month, day, and year) Apr 22 18607 AGE Years 61 Months 11 Days 28 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Liveryman(b) General nature of industry, business, or establishment in which employed (or employer) Horse dealer(c) Name of employer Proprietor

## 9 BIRTHPLACE (city or town)

(State or country) St Marys County Maryland10 NAME OF FATHER John Wesley Tippett11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys County Md.12 MAIDEN NAME OF MOTHER Josephann Bean13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys County Md.

## 14

Informant Mrs Maria Bean Tippett  
(Address) 307 Md. Ave Westport

## 15

MAR 23 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 22 March 192217 I HEREBY CERTIFY, That I attended deceased from 14 March 1922, to 21 March 1922, that I last saw him alive on 21st March 1922, and that death occurred, on the date stated above, at 7:15 A m.

The CAUSE OF DEATH\* was as follows:

Endocarditis(duration) yrs. 6 mos. ds.CONTRIBUTORY Edema of Lungs  
(Secondary)(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw. Woodruff M. D.22 Mar 1922 (Address) 234 Md Ave Westport

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Woodlawn Cem

## DATE OF BURIAL

Mar 24 1922

## 20 UNDERTAKER

W. A. Smith

## ADDRESS

1823 7th Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 62710

D 62710

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2710 Alameda Ave. ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sarah C. Petty

(a) RESIDENCE. No. 2710 Alameda ST. 9 WARD.

(Usual place of abode) Length of residence in city or town where death occurred 64 yrs. 7 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

16 DATE OF DEATH (month, day, and year) 3/21 1922

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas C. Petty

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1922, to March 20, 1922, that I last saw her alive on March 20, 1922, and that death occurred, on the date stated above, at 4:30 A.M.

6 DATE OF BIRTH (month, day, and year) July 9, 1857 7 AGE Years Months Days 64 8 1 If LESS than 1 day, hrs. or min.

The CAUSE OF DEATH\* was as follows: Bronchial Pneumonia

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer) at Home (c) Name of employer

(duration) yrs. 1 mos. 5 ds.

9 BIRTHPLACE (city or town) (State or country) Md.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

10 NAME OF FATHER Nicholas Collison

18 Where was disease contracted if not at place of death?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

Did an operation precede death? Date of

12 MAIDEN NAME OF MOTHER Susan Hagerty

Was there an autopsy? No

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

What test confirmed diagnosis?

14 Informant Thos. C. Petty (Address) 2710 Alameda Ave.

(Signed) E. L. Zimmerman, M. D.

15 MAR 23 1922 ROBERT K. KRAUTER, Burial Permit Registrar

19 (Address) 2858 Harford Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Balt Cem. 3/24 1922

20 UNDERTAKER Philip Henry

Address 2016 Orleans

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62711

## CERTIFICATE OF DEATH.

D 62711

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *15-13 W. Franklin* ST. *19* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

WARD.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Infant*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Mar. 19-22*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*3*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balto. City Ind.*

10 NAME OF FATHER

*Therman Berley*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Westminster Ind.*

12 MAIDEN NAME OF MOTHER

*Bessie Townsend*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balto. City Ind.*

14

Informant (Address)

*Therman Berley 15-13 W. Franklin St.*

15

Filed

MAR 23 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 22 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar. 19-1922, to Mar. 21-1922,*that I last saw him alive on *Mar. 21 1922,*and that death occurred, on the date stated above, at *7-20 A. M.*

The CAUSE OF DEATH\* was as follows:

*Premature birth (8 months)*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *no*Was there an autopsy? *no*What test confirmed diagnosis? *none*(Signed) *Chas. C. McLaughlin* M. D., 19 (Address) *906 N. Street N.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Christ Cemetery**Mar. 23 1922*

20 UNDERTAKER

ADDRESS

*Geoff B. Cook**1003 N. Baltimore*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



State  
Physicians should  
state  
Exact statement of OCCUPA-  
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 62712

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

23 D 62712

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2640 N. Calvert. ST., 12 WARD)

2-FULL NAME

Sarah Sutton Corse

(a) RESIDENCE NO.

2640 N. Calvert ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

79 yrs. 3 mos. 2

ds. How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 COLOR OR RACE

Widow

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

George F. Corse

6 DATE OF BIRTH (month, day, and year)

Mar 20 1842

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

79

3

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

retired

(b) General nature of industry, business, or establishment in which employed (or employer)

ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md.

10 NAME OF FATHER

James L. Sutton

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Penna

12 MAIDEN NAME OF MOTHER

Elizabeth Hewes

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant Ella Corse Meryinger (Address) 2640 N. Calvert St.

15

ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 22 1922

17

I HEREBY CERTIFY, That I attended deceased from Mar 22 1922 to Mar 22 1922.

that I last saw him alive on Mar 22 1922.

and that death occurred, on the date stated above, at 3:40 P. m.

The CAUSE OF DEATH\* was as follows:

Encephalitis lethargica (Probable diagnosis — Dr. Fletcher D. Watson)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm J. Watson, M. D.

(Address) 2128 St Paul

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Friends Cemetery Mar 24 1922

20 UNDERTAKER

ADDRESS

John Orntichell 1201 W. Fayette

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. - 1-10-21 - M&T - 1500 Bks.

D 62713

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 S. Ellwood Ave. WARD)

2-FULL NAME Charles M. Erdbrink

(a) RESIDENCE NO. 818 S. Ellwood Ave. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10 - 1920

7 AGE Years 1 Months 8 Days 12 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md. (State or country)

10 NAME OF FATHER James L. Erdbrink

11 BIRTHPLACE OF FATHER (city or town) Balto., Md. (State or country)

12 MAIDEN NAME OF MOTHER Barbara H. Weidner

13 BIRTHPLACE OF MOTHER (city or town) Balto., Md. (State or country)

14 Informant James L. Erdbrink (Address) 818 S. Ellwood Ave.

15 MAR 23 1922 ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 - 1922

17 I HEREBY CERTIFY, That I attended deceased from March 1<sup>st</sup>, 1922, to March 22, 1922, that I last saw him alive on March 21<sup>st</sup>, 1922,

and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH\* was as follows:

Brachio Pneumonia

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Inscription  
(Signed) H. J. Schwab M. D.

3/22/22 (Address) 734 S. Ellwood Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Oak Lawn Cem.

March 24 1922

20 UNDERTAKER

ADDRESS

Lilly and Ziehl

403 S. Wolfe St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62714

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 133 N. Linwood Ave. ST. 6 WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 133 N. Linwood Ave. ST. 6 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel J. Cahill.6 DATE OF BIRTH (month, day, and year) Nov. 30 - 18647 AGE Years 57 Months 3 Days 20 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md10 NAME OF FATHER August Bartholomew11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Emma Burkhardt13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany14 Informant Howard J. Cahill (Address) 133 N. Linwood Ave.15 MAR 23 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/20/22 1917 I HEREBY CERTIFY, That I attended deceased from Oct, 1921, to March 1922, that I last saw her alive on March 1922, and that death occurred, on the date stated above, at 9:16 A. m. The CAUSE OF DEATH\* was as follows:Pulmonary TuberculosisCONTRIBUTORY (Secondary) Tuberculosis (T.B.) (duration) yrs. 9 mos. ds.18 Where was disease contracted if not at place of death? BelgiumDid an operation precede death? No Date of ✓Was there an autopsy? NoWhat test confirmed diagnosis? Microscopic Sputa(Signed) Alexander J. Leno, M. D., 19 (Address) 1855 N. Charles St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cah Lawn Cem.

DATE OF BURIAL

3/23/22

20 UNDERTAKER

Lilly and Zeller

ADDRESS

403 S. N. 1st St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 62715 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62715

## CERTIFICATE OF DEATH.

31

## 1-PLACE OF DEATH

## REGISTERED NO.

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Douglas

(a) RESIDENCE. NO. 432 Belnord ave. } or Belnord House }  
on Front St. WARD. G. H. Green

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

ds. How long in U. S., if of foreign birth Unknown mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Not stated

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 59

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone mason

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Scotland (State or country)

10 NAME OF FATHER James Douglas

11 BIRTHPLACE OF FATHER (city or town) Scotland (State or country)

12 MAIDEN NAME OF MOTHER Jean Allison

13 BIRTHPLACE OF MOTHER (city or town) Scotland (State or country)

14 Informant Hospital records (Address) M.T.H.

15 Filed MAR 23 1922

ROBERT H. KRAUTER, Registrar

16 DATE OF DEATH (month, day, and year) March 22, 1922

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1922, to March 22, 1922.

that I last saw him alive on March 22, 1922.

and that death occurred, on the date stated above, at 5.40 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis T.B. on sputum, X-ray

(Signed) Francis L. DeGagliacea D

8-22-22, 19 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Carmel Cemetery Harris 1922

20 UNDERTAKER ADDRESS

H. Sander &amp; Sons 1710 Fleet St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D 62716

HEALTH DEPARTMENT—CITY OF BALTIMORE

62716

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 W East Ave \* 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Eversmeier

(a) RESIDENCE NO. 20 W East Ave \* (Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Catherine Eversmeier

6 DATE OF BIRTH (month, day, and year) March 15-1853

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 69 0 6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore

(c) Name of employer Manufacturer Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Frederick Eversmeier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. Elizabeth Mayer (Address) 20 W East Ave

15 MAR 23 1922 ROBERT H. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1922

17 I HEREBY CERTIFY, that I attended deceased from Feb 4 1922 to Mar 21 1922

that I last saw him alive on May 20 1922

and that death occurred, on the date stated above, at 2 10 A. M.

The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis

CONTRIBUTORY (Secondary)

(duration) yrs. 16 mos. 16 ds. Central Hemiplegia

(duration) yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Tumor Symptom (Signed) G. L. B. Lades M. D.

(Address) 14376 Bony

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mount Carmel Cemetery Mar 24 1922

20 UNDERTAKER

ADDRESS

H. Sander & Sons 1710 Fleet St

62717

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 2 WARD)2-FULL NAME George W. Keys(a) RESIDENCE. No. 1742 Lancaster StST. 2 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
----------------------	---------------------------------	--

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
<u>66</u>		<u>--</u>	<u>--</u>	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workProcessor(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,  
(State or country) Maryland10 NAME OF FATHER James Keys11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Dorchester Co., Md.12 MAIDEN NAME OF MOTHER Eliza Hudgins13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Virginia14 Informant Hospital Records,  
(Address) Municipal Hospital.15 MAR 23 1922 ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 19 22

17 I HEREBY CERTIFY, That I attended deceased from  
March 21, 19 22, to March 21, 19 22,  
that I last saw him alive on March 21, 19 22,  
and that death occurred, on the date stated above, at 6:50 P.M.

The CAUSE OF DEATH\* was as follows:

Chronic myocarditis(duration) 3 yrs. mos. ds.CONTRIBUTORY  
(Secondary)Myocardial insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

3/21/22 Address Municipal Hospital.\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Carmel CemeteryMar 24 1922

20 UNDERTAKER

ADDRESS

H. Sander & Sons1701 E. 21st St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

D 62718 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62718

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 James ST. 21 WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 1207 James

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE 5 Single Married, Widowed, or Divorced (Use the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23-1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

MAR 23 1922

Burial Permit

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 12 1922

17

I HEREBY CERTIFY, That I attended deceased from

Mar 10, 1922, to Mar 15, 1922,

that I last saw him alive on Mar 22, 1922,

and that death occurred, on the date stated above, at 4:27 P.M.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Saml P. Boyd, M. D.

(Address) 602 E. North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or Intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior.*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62719

## CERTIFICATE OF DEATH.

44D 62719

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Calash Lane Reland Park* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. *Calash Lane Reland Park* ST. *Calash* WARD

(Usual place of abode)

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth *Life* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*6a If married, widowed, or divorced HUSBAND of *Emma F. Bitter* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *Dec. 31/1869*7 AGE Years *52* Months *2* Days *086* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Insurance*(b) General nature of industry, business, or establishment in which employed (or employer) *Business*

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Md.*10 NAME OF FATHER *Detrich Bitter*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Marie Bitter*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)14 Informant *Emma F. Bitter* (Address) *Calash Lane Reland Park*15 *MAR 23 1922* ROBERT R. KRAUTER, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 21 1922*17 I HEREBY CERTIFY, That I attended deceased from *Feb 20*, 1922, to *March 21*, 1922.that I last saw him alive on *March 21*, 1922, at *8 P.* m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Liver*(duration) yrs. *3* mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date of *✓*Was there an autopsy? *no*What test confirmed diagnosis? *Clinical symptoms*(Signed) *J. B. Schwatka*, M. D.Address) *822 W. North Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE. *London Park* DATE OF BURIAL *Mar 24 1922*ADDRESS *William Oak 5026 North Ave*

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

*J. B. Schwatka 8124 North Ave.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D

62720

## CERTIFICATE OF DEATH.

100-1001  
D 62720

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

964 N. Collington St.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Emma Kuntz

(Residence in Baltimore: No.

964 N. Collington Ave

St.; 36 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE

White

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

## 6-DATE OF BIRTH

Not known

(Month)

(Day)

(Year)

## 7-AGE

56

yrs.

mos.

ds.

If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

037

## 9-BIRTHPLACE,

(State or Country),

Bohemia

## 10-NAME OF FATHER,

Martin Dazek

## 11-BIRTHPLACE OF FATHER

(State or Country),

Bohemia

## 12-MAIDEN NAME OF MOTHER

Rusi Stokrot

## 13-BIRTHPLACE OF MOTHER

(State or Country),

Bohemia

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

James Kuntz

(Address)

964 N. Collington Ave

## 15-

Filed..... 191.....

MAR 23 1922

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

Mar 22, 1922  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

Mar 15, 1922 to Mar 22, 1922

that I saw him alive on Mar 22, 1922

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH\* was as follows:

Myocardial degeneration  
and arteriosclerosis

(Duration)..... yrs..... mos..... ds.

## CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

3-22-22 (Address) 802 N. Ball St. Bk. 12

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer

## DATE OF BURIAL,

Mar 24, 1922

## 20-UNDERTAKER

J. J. Kuntz

## ADDRESS

100 N. Hollands

1. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 62721

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161- D 62721

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 N. Gay

ST. 5 WARD)

2-FULL NAME

John Louis Wittenburg

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

522 N. Gay

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Yrs.

mos.

ds.

How long in U. S., if of foreign birth?

Yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year)

Feb 15-1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None job

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt to Md.

10 NAME OF FATHER

John Wittenburg

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Eda E. Helfferich

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt to Md.

14

Informant (Address)

John Wittenburg 522 N. Gay St.

15

Filed

MAR 23 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-22 1922

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1922 to March 22, 1922 that I last saw him live on March 21, 1922 and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Premature Birth (only 6 month fetus)

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary)

Cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

pending

(Signed)

3-22-22 F. F. Kelly M. D.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Church Mar 25 1922

20 UNDERTAKER

ADDRESS

Charles W. Coulter 524 E. Eager

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62722

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 St Bond St ST.: 6 WARD)

2-FULL NAME

(a) RESIDENCE. No. 119 St Bond ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male white Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 1921

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAR 23 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1922

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1922, to March 22, 1922.

that I last saw him alive on March 22, 1922.

and that death occurred, on the date stated above, at 3:11 pm.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

M. D.

3/23/22 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



D 62723 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62723

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 950 N Washington St. ST.; 7 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abraham Morris Seidel(Residence in Baltimore: No. 950 N Washington St. St.; 50 yrs., 50 mos., 50 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH,

Sept. 20, 1922, 1 (Month) (Day) (Year)

7-AGE,

99— yrs., — mos., — ds.

If LESS than 1 day,

— hrs. or — min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Sailor  
(b) General nature of industry, business, or establishment in which employed (or employer), 880

9-BIRTHPLACE,

(State or Country), Russia

PARENTS.

10-NAME OF FATHER,

Simon Seidel

11-BIRTHPLACE OF FATHER

(State or Country), Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Heirs(Address), 1411 E 13th St

15-

Filed

MAR 23 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 22, 1922, (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Feb 20, 1922, to March 21, 1922,that I saw him alive on March 22, 1922,and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH\* was as follows:

Myocardial infarction  
(Duration) — yrs., — mos., — ds.CONTRIBUTORY  
(Secondary)(Signed) M. D. Koffelman M. D.  
3/23/22 191... (Address) 1515 N. Bental

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs., — mos., — ds. In the — yrs., — mos., — ds. State —

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Abraham Seidel

DATE OF BURIAL,

3/23, 1922

20-UNDERTAKER

Jack Lewis

ADDRESS

1411 E 13th St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

546  
D 62724

HEALTH DEPARTMENT—CITY OF BALTIMORE D 62724

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7 WARD)

2-FULL NAME

Samuel Ewing

(a) RESIDENCE NO.

2901 South St

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Dallas Texas

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

5a If married, widowed, or divorced

(or) WIFE of

Mrs. Ruggie Ewing

6 DATE OF BIRTH (month, day, and year)

May 21, 1862

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

59 years

10

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

oleb

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Texas

10 NAME OF FATHER

Samuel Ewing

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Texas

12 MAIDEN NAME OF MOTHER

Mary Honey

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Texas

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

MAR 23 1922

ROBERT R. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1922

17

I HEREBY CERTIFY, That I attended deceased from March 19, 1922, to March 23, 1922, that I last saw him alive on March 23, 1922, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH\* was as follows:

Operative

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Operation

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

C. E. Stueck M. D.

323, 1922 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Dallas, Texas

DATE OF BURIAL

3-23-22

20 UNDERTAKER

Jack Lewis, 1439 E. 6th

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 9-19-H. P. Co.—1900 Bks.

D 62725

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

X 90 D 62725

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *835 Park Ave*)

ST.: *11* WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *James B. Thomas.*

(a) RESIDENCE. No. *835 Park Ave*  
(Usual place of abode)

ST., WARD.

*Phila Pa*

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *0* yrs. *6* mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of *Lizzie Grant.*

6 DATE OF BIRTH (month, day, and year) *March 24, 1834*

7 AGE Years *77* Months *11* Days *24* If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired*  
(b) General nature of industry, business, or establishment in which employed (or employer) *None*  
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Chester Co., Pa.*

10 NAME OF FATHER *Morgan Thomas*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Chester Co., Pa.*

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Chester Co., Pa.*

14 Informant *George H. Gron*  
(Address) *1007 Cathedral St.*

15 *MAR 23 1922* **ROBERT R. KRAUTER,**  
Registrar  
Burial Permit Clerk.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-28-22* 19

17 I HEREBY CERTIFY, That I attended deceased from *March 6, 1922*, to *March 23, 1922*, that I last saw him alive on *March 22, 1922*, and that death occurred, on the date stated above, at *5 A.* m. The CAUSE OF DEATH\* was as follows:

*Cardio-Renal disease*

(duration) *15* yrs. — mos. — ds.

CONTRIBUTORY *Myocardia Insufficiency*  
(Secondary)

(duration) — yrs. — mos. *5* ds.

18 Where was disease contracted if not at place of death? *Philadelphia.*

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Clinical*

(Signed) *George H. Gron*, M. D.

, 19 (Address) *1007 Cathedral St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Phila Pa* *March 28, 1922*

20 UNDERTAKER ADDRESS

*Henry Jenkins & Co* *Georgetown, D.C.*

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62726

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 N. Eads ST., 6 WARD)

### 2-FULL NAME

Margaret H. Pfeiffer

### (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernard Pfeiffer

6 DATE OF BIRTH (month, day, and year) Dec. 12, 1837

7 AGE Years 84 Months Days If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

10 NAME OF FATHER Joseph Kern

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth S. S. S.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret H. Pfeiffer (Address) 132 N. Eads

15 Filed MAR 23 1922 19 ROBERT R. KRAUTER Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1922

17 I HEREBY CERTIFY, That I attended deceased from March 4, 19 22 to March 21, 19 22, that I last saw her alive on March 21, 19 22, and that death occurred, on the date stated above, at 8 P.M. The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) Chronic nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? (Signed) John T. Quinn M. D.

(Address) Farmers Bldg + 100

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL London Park DATE OF BURIAL Mar 24 1922

20 UNDERTAKER Wm Cook ADDRESS N + G. N.Y.



N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62727

# HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH

D 62727

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 506 Rose Hill Terrace

ST. 9

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J. Rhinepeltz

(Residence in Baltimore: No. 506 Rose Hill Terrace

St.:

yrs.

mos.

ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

June

22, 1874

(Month)

(Day)

(Year)

7-AGE

47

9

mos.

ds.

If LESS than

1 day, .... hrs.

or .... min.?

8-OCCUPATION

(a) Trade, profession, or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

Capt. Police  
Police Dept.

9-BIRTHPLACE

(State or country)

Balt. City

10-NAME OF FATHER

Jeremiah Rhinepeltz

11-BIRTHPLACE OF FATHER

(State or country)

Balt. City

12-MAIDEN NAME OF MOTHER

Jane Anderson

13-BIRTHPLACE OF MOTHER

(State or country)

Balt. City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. John Daily

(Address)

713 E 21st St.

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

March

22, 1922

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

Feb 21, 1922, to March 22, 1922

that I saw him alive on March 21, 1922

and that death occurred, on the date stated above, at 8:48 m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial  
Nephritis

(Duration) 1 yrs.

mos.

ds.

Contributory

(SECONDARY)

Uraemic Poisoning

(Duration) 3 yrs.

mos.

ds.

(Signed)

James M. Denton

M. D.

Mar 23, 1922 (Address) 700 (Chas St)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

8 yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

506 Rose Hill Terrace

506 Rose Hill Terrace

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Cathedral

March 24, 1922

20-UNDERTAKER

ADDRESS

W. W. Wiedefeld

501 E 22nd St

Robert P. Harrison,

191

Burial Permit Clerk

REGISTRAR

AR 23 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 62728

HEALTH DEPARTMENT—CITY OF BALTIMORE D 62728

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 N. Payson

ST. 16 WARD)

2-FULL NAME

Charlotte Lee Euer

(a) RESIDENCE. No. 606 N. Payson

ST. 16 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced. (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct-12-1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md  
Edgar L Euer

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md  
Lilly Baker

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

Mrs. Lillian Baker  
606 N. Payson

15

MAR 23 1922

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

16

ST. 16 WARD)

ST. 16 WARD.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-22-1922

17

I HEREBY CERTIFY, That I attended deceased from March 19th, 1922, to March 22nd, 1922,

that I last saw her alive on March 22, 1922,

and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 3 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) B. E. Swickery, M. D.

(Address) 400 N. Payson

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Cem.

Mar 24 1922

20 UNDERTAKER

ADDRESS

Wm. J. Tackner & Son

N. Pa

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior*

Physicians should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62729

CERTIFICATE OF DEATH.

100-000 62729

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 445 Park Heights ST. 15 WARD)

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Murray Bier

(a) RESIDENCE NO. 445 Park Heights ST. (Usual place of abode)

WARD (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 5 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence Bier

6 DATE OF BIRTH (month, day, and year) Sept. 30/859

7 AGE Years 62 Months 5 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Clothing Fitter 869 (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer Lippincott Brothers

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

10 NAME OF FATHER David H. Murray

11 BIRTHPLACE OF FATHER (city or town) Dublin Ireland (State or country)

12 MAIDEN NAME OF MOTHER Johanna White

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Miss Kate Murray (Address) 445 Park Heights St.

15 Filed MAR 23 1922 Registrar J. M. M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 23 1922

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1922, to Mar. 23, 1922.

that I last saw her alive on Mar 22, 1922.

and that death occurred, on the date stated above, at 7.00 a m.

The CAUSE OF DEATH\* was as follows:

Pneumonia (duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James C. Clark M. D.

Address 2470 E. 1st St. Baltimore

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL London Park

DATE OF BURIAL 1922

20 UNDERTAKER

ADDRESS North

2071 Hickman St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62730

D 62730

1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

REGISTERED NO.

CITY OF BALTIMORE: (No. 1416 McCulloh ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

7

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Solomon Holmes

6 DATE OF BIRTH (month, day, and year) Dec 14, 1835

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

86

3

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

MAR 23 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 7, 1922, to March 22, 1922,

that I last saw her alive on March 22, 1922,

and that death occurred, on the date stated above, at 2:45 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed)

William H. Wright, M. D.

(Address) 1209 Broadman St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn Cnty

Mar 26 1922

20 UNDERTAKER

George T. A. Gibson

ADDRESS

513 Lehigh

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION should be stated EXACTLY. PHYSICIANS should be supplied. AGE should be stated EXACTLY. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62731

D 62731

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 10 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Cantwell(a) RESIDENCE. No. 1023 Central Ave ST.  WARD. 

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18567 AGE Years Months Days If LESS than 1 day, hrs. or min. 65 -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland10 NAME OF FATHER John Cantwell11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Henrietta Dupon13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant Hospital Records, (Address) Municipal Hospital.15 Filed 1922, 191903 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 192217 I HEREBY CERTIFY, That I attended deceased from March 10, 1922 to March 20, 1922.that I last saw him alive on March 20, 1922.and that death occurred, on the date stated above, at 11:40 A.

The CAUSE OF DEATH\* was as follows:

Myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde M. Mule M. D.3/20/22 address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITALMAR 2 1922

20 UNDERTAKER

ADDRESS

Commissioner Health,E. WOODALL

maison should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 62732

D 62732

CERTIFICATE OF DEATH

1-PLACE OF DEATH

South Balto. General Hospital 101-061

REGISTERED No.

CITY OF BALTIMORE: (No.

ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William Moore

(a) RESIDENCE. No.

826 Bevan St

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

ys.

mos.

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug. 24, 1888

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

34 yrs

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

S. C.

10 NAME OF FATHER

John Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

?

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Deceased

15

19

Robert F. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22, 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 21, 1922, to March 22, 1922,

that I last saw him alive on March 22, 1922,

and that death occurred, on the date stated above, at 2:10 P. M.

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia

(duration)

ys.

mos.

5 ds.

CONTRIBUTORY (Secondary)

Endocarditis

(duration)

ys.

mos.

7 ds.

18 Where was disease contracted?

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Carl F. Benson

M. D.

, 19

(Address) South Balto. General Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

HOPKINS HOSPITAL

19

20 UNDERTAKER

Commissioner Health,

ADDRESS

MAR 23 1922

MAR 23 1922

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62733

## CERTIFICATE OF DEATH.

74-001  
D 62733

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1410 N. Patterson Park Ave. 8 WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME Alice Brown

(a) RESIDENCE No. 1410 N. Patterson Park Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 6 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur L. Brown

6 DATE OF BIRTH (month, day, and year) Aug. 27, 1854

7 AGE Years Months Days If LESS than 1 day, hrs or min. 67 6 23

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER Frank Luke

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Stout

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Arthur L. Brown (Address) 1410 N. Patterson Park Ave.

15 Filed 19 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 22nd 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 10, 1922, to March 22, 1922, that I last saw him alive on Mar 22, 1922, and that death occurred, on the date stated above, at 2 P. M. The CAUSE OF DEATH\* was as follows:

Central hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt J. Green, M. D.

3-23, 1922 (Address) 120 Bisquit St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Loudon Park Cemetery

3/24/ 1922

20 UNDERTAKER

ADDRESS

E. I. Fanning & Son-1938 E. Lafayette Av

AR 23 1922

Burial Permit No. 12



D 62734

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62734

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE (No. 1634 *Alliciana St.* ST. 7 WARD)FULL NAME *Charles E. Collins*(Residence in Baltimore: No. *821 N Wolfe*)

## REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Days mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Male*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) *Single*

## 6-DATE OF BIRTH,

*Oct 11**1866*

## 7-AGE,

*55* yrs. *5* mos. ds.

If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)*Spelman*

## 9-BIRTHPLACE,

(State or Country), *Baltimore Md*10-NAME OF FATHER, *James V. Collins*11-BIRTHPLACE OF FATHER (State or Country), *Ireland*12-MAIDEN NAME OF MOTHER, *Mary E. Flemming*13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *John D. Collins*(Address), *108 S. Chester*

## 15-

Robert P. Harrison,

Filed, 101

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

(Month) (Day) (Year) *Nov 22, 1912*

## 17-I HEREBY CERTIFY, That I took charge of the remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

*suicide*  
*gunshot wound*  
(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D. (Coroner.)

(Address) State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

## Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*Belgrave Park Rd. Baltimore, Md. 28. 22*

## 20-CORONER'S ADDRESS

*William C. Adams*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R 23 1922 Burial Permit Clerk.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62735

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE (No. 1743 Bell St. ST. 24 WARD)

## 2. FULL NAME

John H. Knickman

## (a) RESIDENCE NO.

1743 Bell St.

ST. 24 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Maria Amelia Knickman

6 DATE OF BIRTH (month, day, and year)

May 10-1878

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

77

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

OOD

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

John Knickman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Catherine Knickman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md.

14

Informant (Address)

Mrs. Clara Seeds 2107 Elm St.

15

Robert F. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22 1922

17

I HEREBY CERTIFY, That I attended deceased from March 5, 1922, to March 22, 1922.

I last saw him alive on March 22, 1922.

and that death occurred, on the date stated above, at 830 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary)

Pulmonary edema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

no Date of

Was there an autopsy?

no paralysis

What test confirmed diagnosis?

(Signed) Jas. A. O'Donnell M. D. 3/22/22 (Address) 1572 West St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Baltimore

DATE OF BURIAL

Mar. 24 1922

20 UNDERTAKER

Wm. Corb

ADDRESS

1572 West St.

CAUTION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 23 1922

Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 12-21 M&T 1500 Bks.

(Brookes)  
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62736

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 Otterbein ST. 71 WARD)

2. FULL NAME

Thomas Brookes

(a) RESIDENCE NO.

509 Otterbein

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

Do not know

6 DATE OF BIRTH (month, day, and year)

1864

7 AGE

58

Years

Months

Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Own holder

(b) General nature of industry, business, or establishment in which employed (or employer)

047

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

Harry Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto

12 MAIDEN NAME OF MOTHER

Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant (Address)

Calvin R. Richardson 509 Otterbein St

15

Robert P. Harrison, Registrar

AR 23 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 23 1922

17

I HEREBY CERTIFY, That I attended deceased from Mar. 29, 1922, to Mar. 23, 1922, that I last saw him alive on Mar. 22, 1922, and that death occurred, on the date stated above, at 1 H. m. The CAUSE OF DEATH\* was as follows:

Acute interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

cardiac asthma (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Yes

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical

(Signed)

3/23, 1922 (Address) 196 Columbia Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mount Olivet Co. Freedman Park

20 UNDERTAKER

William Cook

DATE OF BURIAL

March 25 1922

ADDRESS

502 E. Pratt St

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

Possibly alcoholism



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62737

## CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos. 21 ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

It LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MAR 24 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Inhalation of Chlorine Gas

CONTRIBUTORY (Secondary)

(Signed) M. D.

3.23. 1922 Address: 112 W. Lexington

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs... mos... ds. State... yrs... mos... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Washington D.C.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER,

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62738

D 62738

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Women's Hospital* ST. *27* WARD)2-FULL NAME *Carolyn Leigh Jones*(a) RESIDENCE. No. *501 Hawthorne Road* ST. *27* WARD. *Resident*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *18* yrs. *?* mos. *?* ds. How long in U. S., if of foreign birth? *44* yrs. *1* mos. *12* ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Alvan Levin Jones*6 DATE OF BIRTH (month, day, and year) *Feby-11-1878*7 AGE Years Months Days If LESS than 1 day. hrs. or min.  
*44* *1* *12*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none 037*

(b) General nature of industry, business, or establishment in which employed (or employer)

*none*

(c) Name of employer

*none*9 BIRTHPLACE (city or town)  
(State or country)*Columbus  
Mississippi*

10 NAME OF FATHER

*not known*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Mississippi*

12 MAIDEN NAME OF MOTHER

*not known*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Mississippi*14 Informant *Mrs. A. L. Jones (husband)*  
(Address) *501 Hawthorne Road*15 Filed *19*ROBERT R. KRAUTER,  
Registrar

MAR 24 1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 23* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar. 10, 1922* to *Mar. 23*, 19 *22*.that I last saw her alive on *Mar. 23*, 19 *22*.and that death occurred, on the date stated above, at *10<sup>00</sup>* A. m.

The CAUSE OF DEATH\* was as follows:

*Septicemia  
(following operation)*

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

*Cancer of Uterus* (duration) *?* yrs. mos. ds.

18 Where was disease contracted?

if not at place of death?

Did an operation precede death? *Yes* Date of *Mar. 24, 1922*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *G. F. Goff* M. D.19 (Address) *Woman's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Petersburg Va**Mar 25 / 1922*

20 UNDERTAKER

STEWART & MOWEN COMPANY  
(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE

Physicians should state EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 62739

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1100* Hospital ST.: *6* WARD)

## 2-FULL NAME

*Aaron Erdman*(a) RESIDENCE. No. *220 N Bond St.* ST.: *17* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *17* yrs. mos. ds.How long in U. S., if of foreign birth? *17* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*m*

4 COLOR OR RACE

*w*

5 Single, Married, Widowed, or Divorced (write the word)

*married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Rebecca Erdman*

6 DATE OF BIRTH (month, day, and year)

*1868*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*54*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Cabinet maker*

(b) General nature of industry, business, or establishment in which employed (or employer)

*114*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Russia*

10 NAME OF FATHER

*Unknown*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Russia*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Russia*

14

Informant  
(Address)*Rebecca Erdman  
220 N. Bond St.*

15

File

*MAR 24 1922**ROBERT R. KRAUTER*

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3/23 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*November 10, 1921, to March 23, 1922.*that I last saw him alive on *March 23, 1922.*and that death occurred, on the date stated above, at *1:15 p. m.*

The CAUSE OF DEATH\* was as follows:

*Pneumonia*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

*Unknown*

Did an operation precede death?

*no*

Was there an autopsy?

*no*

What test confirmed diagnosis?

(Signed) *Shore, Paulsen,* M. D.

, 19 (Address)

*Helber Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Worship Circle**3/24 1922*

20 UNDERTAKER

ADDRESS

*Jack Lewis 1439 E. Baltimore*





D 62741

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

D 62741

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No.

ST.

WARD

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

19

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23, 1922

17

I HEREBY CERTIFY, That I attended deceased from March 22, 1922, to March 23, 1922, that I last saw him alive on March 23, 1922,

and that death occurred, on the date stated above, at 11.30 Am.

The CAUSE OF DEATH\* was as follows:

Shock following operation.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

at home.

Did an operation precede death?

Yes

Date of

3/23/22

Was there an autopsy?

Partial Autopsy

What test confirmed diagnosis?

none.

(Signed)

Wm. E. Lillhardt

M. D.

Address) 1922

Kehrer Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Kehrer-Frendeluf

3/24 1922

20 UNDERTAKER

ADDRESS

Jock Lewis 1439 5th St. Balt.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 24 1922

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Cerebral hemorrhage  
probably due to injury  
at birth.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

101-62742

D 62742

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 Evans Chapel Road 27

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME Sarah A. Machin

(a) RESIDENCE NO. 4 Evans Chapel Road ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

1 yrs. 13 mos.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Joseph H. Machin

6 DATE OF BIRTH (month, day, and year)

April 30-1842

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

79

10

21

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Co. Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Charlotte Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Miss Charlotte J. Machin 4 Evans Chapel Road

MAR 24 1922

ROBERT R. KRAUTER, Registrar

Burial Permit

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 21 1922

17

I HEREBY CERTIFY, That I attended deceased from Mar 15, 1922, to Mar 21, 1922, that I last saw her alive on 3/21, 1922, and that death occurred, on the date stated above, at 11 A. m. The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. W. D. Hoff M. D.

3/22 1922 Address 1020 N. Charles

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Resurrection Cem. (Balto. Co.)

March 24, 1922

FUNERAL

ADDRESS

Horace F. Burgee 3631 Fall Rd

Physicians should state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

62743

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62743

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin St. Hospital* ST.; *2* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Catherine E. Batching*(Residence in Baltimore: No. *2042 Gough St.* St.; ..... yrs., ..... mos. .... ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *F*4-COLOR OR RACE, *W*5-SINGLE, *Mar.*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

*Aug - 28, 1878*  
(Month) (Day) (Year)

7-AGE,

*43* yrs. *7* mos. .... ds.If LESS than 1 day,  
.... hrs. or .... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Housework*  
(b) General nature of industry, business, or establishment in which employed (or employer), *037*9-BIRTHPLACE,  
(State or Country), *Balto.*10-NAME OF FATHER, *Geo N. Betz*11-BIRTHPLACE OF FATHER  
(State or Country), *Balto*12-MAIDEN NAME OF MOTHER *H. Knowles*13-BIRTHPLACE OF MOTHER  
(State or Country), *Balto*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Hospital Records*

(Address), .....

15-

MAR 24 1922 ROBERT R. KRAUTER,  
Burial Permit Clerk,  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Mar - 23 - 1922, 191...*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

*Feb - 1, 1922, to Mar - 23, 1922,*that I saw her alive on *Mar - 23 - 1922,*and that death occurred, on the date stated above, at *12:30* p.m.

The CAUSE OF DEATH\* was as follows:

*Cholecystitis & Cholelithiasis*(Duration) *2* yrs. .... mos. .... ds.CONTRIBUTORY *Intestinal adhesions*  
(Secondary) *operated on*(Duration) *3* yrs. .... mos. .... ds.(Signed) *Wm. J. Carr* M. D.*3/23, 1922* (Address) *Franklin St. Hosp.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Baltimore, Maryland**March 24, 1922*

20-UNDERTAKER

ADDRESS

*Mendell Appled & Son**37. Howard*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62744

## CERTIFICATE OF DEATH.

31 D 62744

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1820 Fairmount Ave*)ST. *6* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *George M Moser*(a) RESIDENCE NO. *1820 Fairmount Ave*

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*M*

4 COLOR OR RACE

*W*

5 Single, Married, Widowed, or Divorced, (write the word)

*S*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Feb 4, 1906*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*16**1**18*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*School*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balt Md.*

10 NAME OF FATHER

*George Moser*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balt Md*

12 MAIDEN NAME OF MOTHER

*Fanny Gardiner*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balt, Md*

14

Informant (Address)

*George Moser 1820 Fairmount Ave*

15

MAR 24 1922

ROBERT R. KRAUTER, Registrar

Social Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 22 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Jan 1*, 19*22*, to *Mar 22*, 19*22*, that I last saw him alive on *Mar 11*, 19*22*and that death occurred, on the date stated above, at *1:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Diphtheria and Pulmonary*(duration) *7* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Microscopic*(Signed) *Samuel D. ...* M. D., 19 (Address) *3825 Pitt St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Mount Carmel**Mar 23 1922**Wendell S. ...**37 ...*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

D 62745 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62745

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *English* WARD)

## 2-FULL NAME

(a) RESIDENCE No. *English* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *58* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**White**Married*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

*Charles R. Baker*

6 DATE OF BIRTH (month, day, and year)

*July 24 1863*

7 AGE

Years

Months

Days

If LESS than 1 day, 7 hrs. or 2 min.

*58**6**22-7 hrs. 7 min.*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*

10 NAME OF FATHER

*Timothy Connolly*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*County Galway Ireland*

12 MAIDEN NAME OF MOTHER

*Eliza B. Hughes*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*County Antrim Ireland*

14

Informant (Address)

*Mrs. Charles R. Baker*

15

File *MAR 24 1922* ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Mar 22 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Sept 15 1922* to *Mar 22 1922*that I last saw *it* alive on*Mar 18 1922*

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

*Cardiac Atrophy*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

da.

*Uterine Apoplexy*

(duration)

yrs.

mos.

da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

3/24/22 Address

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*London Park**Mar 25 1922*

20 UNDERTAKER

ADDRESS

*Wm. J. Lickertson**N. & Pa.*

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICAL CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

2. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

D 62746

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL ST., 18 WARD)

2-FULL NAME

Baby Walker

(a) RESIDENCE No.

837 Hollins St.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Days

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 16<sup>th</sup> 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Mamie Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

19 PLACE OF BURIAL, CREMATION OR REMOVAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

DATE OF BURIAL

19

ADDRESS

MAR 24 1922

ROBERT H. KRAUTER, Commissioner Health,

Burial Permit Clerk.

Commissioner Health,

Wm. E. WOODALL

MAR 28 1922

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 62747 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 62747

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 646 Greenwillow St ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Henry Jones

(a) RESIDENCE. No. 646 Greenwillow St ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE col 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Jones

6 DATE OF BIRTH (month, day, and year) 1-1-1875

7 AGE 47 Years 2 Months 22 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Elizabeth Jones (Address) 646 Greenwillow St.

15 File MAR 24 1922 ROBERT R. KRAUTER,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-22 1922

17 I HEREBY CERTIFY, That I attended deceased from March 21<sup>st</sup>, 1922, to March 22<sup>nd</sup>, 1922, that I last saw him alive on March 21<sup>st</sup>, 1922, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH\* was as follows:

Hypernephroma (Left kidney) according to history (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Garrison Munk, M. D.

23. 1924 Address 911 Myrtle Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

Address

Burial Permit Clerk



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62748

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 5237 Hunsey St. 17 WARD)

2-FULL NAME

(Residence in Baltimore: No. 5237 Hunsey

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

MAR 24 1922

ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereon and from the evidence obtained by said

find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

(Coroner.)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 62749

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62749

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1039 Cross ST., 21 WARD)

2-FULL NAME

Ervelyn May Karcher

(a) RESIDENCE NO. 1039 Cross

(Usual place of abode)

ST., \_\_\_\_\_ WARD \_\_\_\_\_

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 5 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.  
(State or country)

10 NAME OF FATHER George W. Karcher

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.  
(State or country)

12 MAIDEN NAME OF MOTHER Wass More

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md.  
(State or country)

14

Informant (Address) Wass Karcher  
1039 Cross

15

File 92AD 9 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/23/1922

17

I HEREBY CERTIFY, That I attended deceased from March 5, 1922, to March 23, 1922.

that I last saw him alive on March 23, 1922.

and that death occurred, on the date stated above, at 4:10 m.

The CAUSE OF DEATH\* was as follows:

Failure of Circulation due to pneumonia

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

(Signed) Stephen D. Davis, M. D.

, 19 (Address) 1227 Albemarle St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

London Park

20 UNDERTAKER

James Dequan Hou

DATE OF BURIAL

Mar 24 1922

ADDRESS

1000 Paca

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62750

## CERTIFICATE OF DEATH.

90 D 62750

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1230 N. Gay St. ST., 8 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugo Baschke(a) RESIDENCE NO. 1230 N. Gay St. ST., 8 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie L. Baschke6 DATE OF BIRTH (month, day, and year) Mar 28 - 18527 AGE Years 69 Months 4 Days 25 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080(b) General nature of industry, business, or establishment in which employed (or employed) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)10 NAME OF FATHER Martin Baschke11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Bertha M. Schell13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)14 Informant Annie L. Baschke (Address) 1230 N. Gay St.15 MAR 24 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 192217 I HEREBY CERTIFY that I attended deceased from Nov. 10 1921 to Mar 22 1922 that I last saw him alive on Mar 22 1922and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH\* was as follows:

Aortic Regurgitation(duration) 4 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) 1 mo. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Arthur T. Rogers M. D.(Address) 1407 N. Gay St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Holy Redeemer Cem

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Geo W. Finck & Son811 N. WolfeMARGIN RESERVED FOR BINDING  
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. Form No. 1. Co.—1000 Bks.

D 62751

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62751

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

*Mercy Hospital*

ST.: *15* WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

*Mr Frank J. Augier*

### (a) RESIDENCE. No.

*367 Springdale Ave.*

ST.: \_\_\_\_\_ WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

*11* yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

#### 3 SEX

*Male*

#### 4 COLOR OR RACE

*White*

#### 5 Single, Married, Widowed, or Divorced (write the word)

*Married*

#### 5a If married, widowed, or divorced

HUSBAND of

*Mrs Maudie Augier*

(or) WIFE of

#### 6 DATE OF BIRTH (month, day, and year)

*Dec 22, 1866*

#### 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*55 3 2*

#### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*R.R. Supt.*

(b) General nature of industry, business, or establishment in which employed (or employer)

*073*

(c) Name of employer

#### 9 BIRTHPLACE (city or town) (State or country)

*Ill.*

#### 10 NAME OF FATHER

*Franklin L. Augier*

#### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Vermont*

#### 12 MAIDEN NAME OF MOTHER

*Adaline Smith*

#### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*N.Y.*

#### 14

Informant (Address)

*Mercy Hospital Records*

#### 15

*MAR 24 1922*

*ROBERT R. KRAUTER,*

Registrar

Burial Permit Clerk.

### MEDICAL CERTIFICATE OF DEATH

#### 16 DATE OF DEATH (month, day, and year)

*March 24, 22*

#### 17

I HEREBY CERTIFY, That I attended deceased from *March 18, 22*, to *March 24, 22*.

that I last saw him alive on *March 24, 22*.

and that death occurred, on the date stated above, at *6:58 a.m.*

The CAUSE OF DEATH\* was as follows:

*Acute gangrenous appendicitis*

#### CONTRIBUTORY (Secondary)

(duration) *3* ds.

(duration) *5* ds.

#### 18 Where was disease contracted if not at place of death?

*Home*

Did an operation precede death?

*yes* Date of *3-18-22*

Was there an autopsy?

When test confirmed diagnosis?

*Findings signs & symptoms*

Signed *John J. Brown* M. D.

(Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

#### 19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Woodlawn*

#### DATE OF BURIAL

*3/27 1922*

#### 20 UNDERTAKER

*William Cook*

#### ADDRESS

*502 E North*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62752

## CERTIFICATE OF DEATH.

159-002  
D 62752

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1902 Roe

ST.: 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Virginia Woods

(Residence in Baltimore: No.

1902 Roe St.

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

7-

## 4-COLOR OR RACE,

White

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word)

Single

## 6-DATE OF BIRTH,

March 23, 1922

(Month)

(Day)

(Year)

## 7-AGE,

If LESS than 1 day,

hrs. or 15 min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Infant

## 9-BIRTHPLACE,

(State or Country),

Baltimore - Md.

## 10-NAME OF FATHER,

Harry Woods

## 11-BIRTHPLACE OF FATHER

(State or Country),

Baltimore - Md.

## 12-MAIDEN NAME OF MOTHER

Lena Schaefer

## 13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore - Md.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Woods

(Address) 1902 Roe St.

## 15-

MAR 24 1922 191. ROBERT R. KRAUTER, Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

March 23, 1922

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

191, to 191,

that I saw h. alive on 191,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Congenital heart condition

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Ruth E. Lipman M. D.

March 24 1922 (Address) 2732 York Rd.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Baltimore

## DATE OF BURIAL,

3/24, 1922

## 20-UNDERTAKER

William Cook

## ADDRESS

502 E North

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE <sup>Belt</sup> 62753

D 62753

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1151 Sargent ST.; 21 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annibel Belt(Residence in Baltimore: No. 1151 Sargent, St.; 30 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widow  
(Write the word.)6-DATE OF BIRTH. Jan 7, 1852  
(Month) (Day) (Year)7-AGE. 70 yrs. 2 mos. 16 ds. If LESS than 1 day, ....hrs. or....min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. Stw.  
(b) General nature of industry, business, or establishment in which employed (or employer). ooo9-BIRTHPLACE, (State or Country), Balto Co. Md.10-NAME OF FATHER, Amos Haylor11-BIRTHPLACE OF FATHER (State or Country), Balto Md.12-MAIDEN NAME OF MOTHER Elen. Russell13-BIRTHPLACE OF MOTHER (State or Country), Balto Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Aura S. Haylor(Address) 1151 Sargent15- MAR 24 1922 191. ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 23, 1922.  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Mar 7 1922, to Mar 23 1922, that I saw her alive on Mar 23 1922, and that death occurred, on the date stated above, at 2:10 m. The CAUSE OF DEATH\* was as follows:  
Ch. Sub. Neph.(Duration).....yrs.....2 mos.....ds.CONTRIBUTORY.....  
(Secondary)(Duration).....yrs.....7 mos.....ds.  
(Signed) John E. Schwegman M. D.  
2/23, 1922 (Address) 1120 W. Lewis St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury M. Church DATE OF BURIAL, Mar 25, 192220-UNDERTAKER W. S. Marshall ADDRESS 3539 Falls Road

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

D 62754 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62754

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2115 Boyd ST.; 20 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 2115 Boyd St. St.; 57 yrs., mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married (Write the word.)

6-DATE OF BIRTH. June 20, 1864 (Month) (Day) (Year)

7-AGE. 57 yrs. 9 mos. 2 da. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Watchman (b) General nature of industry, business, or establishment in which employed (or employer). Balto City

9-BIRTHPLACE, (State or Country), Balto.

10-NAME OF FATHER, John Graham

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary McLaughlin

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida Anna Graham

(Address) 2115 Boyd St.

15- Robert P. Harrison, Registrar.

Filed 191. Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 22, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1922 to March 22 1922, that I saw him alive on March 21, 1922, and that death occurred, on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Rectum (Duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary)

(Signed) Charles J. Blake, M. D. March 22, 1922 (Address) 702 E. Pratt St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery DATE OF BURIAL, Mar. 25, 1922

20-UNDERTAKER, Geo. L. Schwab ADDRESS, 201 E. Pratt St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 24 1922

11-11-11  
B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 EKS.

D 62755

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62755

CERTIFICATE OF DEATH.

33

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital

ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Richard Young

(a) RESIDENCE. NO.

620 Sterling St

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

----

6 DATE OF BIRTH (month, day, and year)

1904

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

17

-

--

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

News-boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

George Young

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore, Maryland

12 MAIDEN NAME OF MOTHER

Emma Newman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto., Maryland

14

Informant (Address)

Hospital Records,

Municipal Hospital.

Robert P. Harrison,

19

Burial Permit Clerk,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 20 19 22

17

I HEREBY CERTIFY, That I attended deceased from

March 8 1922, to March 20 19 22

that I last saw him alive on March 20 19 22

and that death occurred, on the date stated above, at 7:40 P.M.

The CAUSE OF DEATH\* was as follows:

Tuberculous peritonitis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? yes Date of 3-15-22

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) J. H. Brumback M. D.

3/21/22 address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Arbury Cemetery

Mar 25 19 22

20 UNDERTAKER

ADDRESS

Chas H Bailey

Jefferson

MAR 24 1922



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62756

## CERTIFICATE OF DEATH.

90 D 62756

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 590 St Marys st ST.; 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hennetta Campbell(Residence in Baltimore: No. 590 St Marys St.; 3 yrs.,  mos.,  ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widow (Write the word.)6-DATE OF BIRTH, 1 (Month) 1 (Day) 1922 (Year)7-AGE, 63 yrs.,  mos.,  ds. IF LESS than 1 day,  hrs. or  min.8-OCCUPATION: (a) Trade, profession, or particular kind of work. odd (b) General nature of industry, business, or establishment in which employed (or employer). None9-BIRTHPLACE, (State or Country), Richmond Va.10-NAME OF FATHER, Unknown11-BIRTHPLACE OF FATHER (State or Country), Unknown12-MAIDEN NAME OF MOTHER Mary Jones13-BIRTHPLACE OF MOTHER (State or Country), Va.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Campbell(Address) 590 St Marys st

15-

Filed Robert F. Hart 191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 20, 1922 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from 15 March 1922, to 20 March 1922 that I saw him alive on March 19 1922, and that death occurred, on the date stated above, at 6 P. m. The CAUSE OF DEATH\* was as follows:Asthma (Duration) 1 yrs., 10 mos.,  ds.CONTRIBUTORY (Secondary) Heart Disease(Signed) Frank M. Johnson M. D. March 21, 1922 (Address) 322 E. Green

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death  yrs.,  mos.,  ds. In the State  yrs.,  mos.,  ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, HOPKINS HOSPITAL DATE OF BURIAL, MAR 21 192220-UNDERTAKER Commissioner Health ADDRESS

Wm F. WOODALL

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MAR 21 1922

19044

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62757

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 267 N Euter ST.; 5 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 267 N Euter St.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Male

## 4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Child

## 6-DATE OF BIRTH,

March 24, 1922  
(Month) (Day) (Year)

## 7-AGE,

one  
If LESS than 1 day, ... hrs. or ... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work... Child  
(b) General nature of industry, business, or establishment in which employed (or employer)...

## 9-BIRTHPLACE, (State or Country),

Balt.

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER (State or Country),

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER (State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Ruggieri

(Address) 267 N. Euter St.

## 15-

File

Robert P. Harrison

191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

March 24, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

March 24, 1922, to March 24, 1922,

that I saw him live on March 24, 1922,

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH\* was as follows:

Premature birth

(Duration) ... yrs. ... mos. ... ds.

## CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Maxwell S. Mayes M.D.

3/24 1922 (Address) 3115 E. Baltimore

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

St. Vincent Cemetery

## DATE OF BURIAL,

March 24, 1922

## 20-UNDERTAKER

George J. Ruth

## ADDRESS

1735 Hayford Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

MAR 24 1922

BURIAL PERMIT

X O D A K S A

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62758

## CERTIFICATE OF DEATH.

D 62758

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Memorial Hospital*)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. *Darlington Maryland*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*March 18, 1868*

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

*Robert F. Harrison,*

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Mar 4 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*March 17, 1922 to March 23, 1922*that I last saw him alive on *March 27, 1922*and that death occurred, on the date stated above, at *8:45 P.M.*

The CAUSE OF DEATH\* was as follows:

*Septic Infection (?) (over) (aplastic anemia?) 4 weeks*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Harford Co. Md. Dublin Cem**March 26 1922*

20 UNDERTAKER

ADDRESS

*H. S. Bailey**Darlington Md*

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

AR 24 1922

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62759

## CERTIFICATE OF DEATH

90 D 62759  
REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No

1232 Leum St

ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME

Catherine Walton

(Residence in Baltimore: No.

1232 Leum St

St. 40 yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

6 DATE OF BIRTH January 12, 1858 (Month) (Day) (Year)

7 AGE 64 yrs. 2 mos. 10 ds. or less than 1 day, hrs. min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Housework 037

9 BIRTHPLACE (State or country) Ireland

10 NAME OF FATHER Michael McGuire

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Reardon (Address) 1732 Leum St

15 Robert P. Harrison, 191 REGISTRAR

Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 22, 1912 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15, 1912, to March 22, 1912, that I saw her alive on March 22, 1912, and that death occurred, on the date stated above, at 3:28 p.m. The CAUSE OF DEATH\* was as follows:

Acute Degeneration of Heart (Duration) yrs. mos. 3 ds. Contributory (SECONDARY) Mitral Regurgitation (Duration) yrs. mos. 7 ds. (Signed) Thos W Stevens M. D. 3/25/12 (Address) 2878 Stanford Rd

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Cathedral Cemetery DATE OF BURIAL Apr 25, 1912

20 UNDERTAKER Margaret J. Lyons ADDRESS 4121 Highland St

MAR 24 1922



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVEN IF INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62760

CERTIFICATE OF DEATH.

74 001 D 62760

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 Tuxed ST., 12 WARD)

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Jackson Stiffler

(a) RESIDENCE NO.

417 Tuxedo

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Charles Stiffler

6 DATE OF BIRTH (month, day, and year)

Feb 12 1840

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

82

1

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

M.D.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Annel Dix 417 Tuxedo St.

15

Robert P. Harrison, Registrar

Barial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 10 1922, to Mar 23 1922, that I last saw him live on Mar 23 1922, and that death occurred, on the date stated above, at 11 40 A.M.

The CAUSE OF DEATH\* was as follows:

Poisoning

CONTRIBUTORY (Secondary)

Cerebral Haemorrhage

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Richardson, M.D. (Address) 112 U. 25 St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St Marys Hampton

Mar 25 22

20 UNDERTAKER

ADDRESS

Chenoweth Son Baltimore

AR 24 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62761

## CERTIFICATE OF DEATH.

62761

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *741 McHenry* ST. *21* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *James Carroll McCain*(a) RESIDENCE. NO. *741 McHenry* ST. WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

*1* yrs. *4* mos. *9* ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Nov. 14 - 1920*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*1**4**1*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore*10 NAME OF FATHER *Larkin L. McCain*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Baltimore*12 MAIDEN NAME OF MOTHER *Euphonia L. Quinlan*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Baltimore*

14

Informant (Address)

*Larkin L. McCain*

15

*Robert F. Harrison*

19

Registrar

*Burial Permit Clerk*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 23 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar. 22, 1922, to Mar. 23, 1922.*that I last saw him alive on *Mar. 22, 1922.*and that death occurred, on the date stated above, at *3 P.* m.

The CAUSE OF DEATH\* was as follows:

*Bronchitis Pneumonia*(duration) yrs. mos. *2* ds.

CONTRIBUTORY (Secondary)

*Cardiac asthma*(duration) yrs. mos. *1/2* ds.18 Where was disease contracted if not at place of death? *Yes*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *Montgomery*

M. D.

(Address) *719 Columbia*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Woodlawn Cemetery**March 25, 1922*

20 UNDERTAKER

ADDRESS

*Geo. L. W. Co. for 647 N. 1st St.*

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 24 1922

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assoc.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection proven*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1, 10, 11—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

### 1. PLACE OF DEATH

CITY OF BALTIMORE: (NO. 154)

JOHNS HOPKINS HOSPITAL ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

### 2. FULL NAME

Leann Cooper

### (a) RESIDENCE NO.

Church Creek Md

ST.

WARD Church Creek

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

interior 3 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

#### 3 SEX

Male

#### 4 COLOR OR RACE

Black

#### 5 Single, Married, Widowed, or Divorced, (write the word)

Married

#### 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Archie Cooper

#### 6 DATE OF BIRTH (month, day, and year)

Oct 8<sup>th</sup> 1872

#### 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

49

5

3

#### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

#### 9 BIRTHPLACE (city or town) (State or country)

Maryland

#### 10 NAME OF FATHER

Alfred Cooper

#### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

#### 12 MAIDEN NAME OF MOTHER

Messine Keane

#### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

#### 14

Informant  
(Address)

JOHNS HOPKINS HOSPITAL

Records

#### 15

Robert F. Harrison

19

Registrar

### MEDICAL CERTIFICATE OF DEATH

#### 16 DATE OF DEATH (month, day, and year)

March 21<sup>st</sup> 1922

#### 17

I HEREBY CERTIFY, That I attended deceased from March 8<sup>th</sup> 1922 to March 21<sup>st</sup> 1922, that I last saw him alive on March 21<sup>st</sup> 1922, and that death occurred, on the date stated above, at 8:40 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary embolism & thrombosis  
Arterio-sclerosis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY Arterio-sclerosis  
(Secondary)

(duration) Several yrs. mos. ds.

#### 18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Mar 11

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. M. Zimmerman, M. D.

Mar, 1922 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

#### 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Adair Cemetery

#### DATE OF BURIAL

March 1922

#### 20 UNDERTAKER

Edward Byron

#### ADDRESS

Orleans St

MAR 25 1922

Burial Permit Clerk



**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDE, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Operation for amputation of leg which was due to gangrene. Arterio-sclerotic. Not diabetic.*

Spec.—1-10-21—M&T—1500 Bks.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62763

CERTIFICATE OF DEATH.

62763

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 Madison Ave. ST. 11 WARD)

REGISTERED NO.  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W. Johnson

(a) RESIDENCE NO. 1118 Madison Ave. ST. WARD

(Usual place of abode) Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of WIFE of Marie Johnson

6 DATE OF BIRTH (month, day, and year) Unknown 1892

7 AGE 30 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Line Man 079

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Cons. Gas & Elec. Co.

9 BIRTHPLACE (city or town) (State or country) Georgia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant L. J. Clark (Address)

15 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/23/1922

17 I HEREBY CERTIFY, That I attended deceased from 3/18/1922 to 3/23/1922 that I last saw him alive on 3/22/1922 and that death occurred, on the date stated above at 12:30 P. M.

The CAUSE OF DEATH\* was as follows: Acute dilatations of the heart

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinic Ave (Signed) A. Lee Ellis M. D.

3-24 1922 (Address) 924 Madison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Oranville Va Undertaker Daniel E. Egan

March 28 1922 ADDRESS 518 Pa

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62764

62764

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 826 W Osteen ST.; 21 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 826 W. Osteen St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE,

1 blk

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

## 6-DATE OF BIRTH,

Sept 12, 1920 (Month) (Day) (Year)

## 7-AGE,

1 yrs. 6 mos. 11 ds.

If LESS than 1 day, ...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer) 000

## 9-BIRTHPLACE, (State or Country),

Calver Co Md

## 10-NAME OF FATHER,

Peter P Brooks

## 11-BIRTHPLACE OF FATHER (State or Country),

Calver Co Md

## 12-MAIDEN NAME OF MOTHER

Rose Briscoe

## 13-BIRTHPLACE OF MOTHER (State or Country),

Calver Co Md

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert P. Harrison

(Address) 826 W Osteen

## 15-

Robert P. Harrison

Filed..... 191..... Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

Mar 23, 1922 (Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Mar 11, 1922, to Mar 23, 1922

that I saw her alive on Mar 23, 1922

and that death occurred, on the date stated above, at 6:10 a m.

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia  
Bronchopneumonia

(Duration)..... yrs..... mos..... ds.

## CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) John G. Sullivan, M. D.

....., 191... (Address) 11200 Leona St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

Calver Co Md

## DATE OF BURIAL,

Mar 26, 1922

## 20-UNDERTAKER

Daniel E. Egan

## ADDRESS

Pa 916

WRITE PLAINLY, WITH OMPASSION FOR THE DEAD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 25 1922

D 62765

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 62765

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Brummell(a) RESIDENCE. No. 641 Pierce St. ST. 17 WARD. (If nonresident give city or town and State)(Usual place of abode) Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18627 AGE Years Months Days If LESS than 1 day, hrs. or min. 59 -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia10 NAME OF FATHER Jacob Brummell11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia14 Informant Hospital Records, Municipal Hospital.15 Robert S. Harrison Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 19 2217 I HEREBY CERTIFY, That I attended deceased from February 11, 19 22, to March 22, 19 22.that I last saw him alive on March 21, 19 22.and that death occurred, on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH\* was as follows:

Cerebral arteriosclerosis(duration) 3 yrs. mos. ds.CONTRIBUTORY Pneumonia (Secondary) (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? (Signed) Chas. M. Neill, M. D.3/22/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Andrew's Church March 2620 UNDERTAKER ADDRESS 916John J. Egan

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 25 1922



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of \_\_\_\_\_ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No hemorrhage.*

D 62766 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62766

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland General Hospital* ST. *2* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

*Mrs. Helen Szczepanik*

## (a) RESIDENCE NO.

*411 South Anne*ST. *2* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

*15* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*white*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*married*

## 5a If married, widowed, or divorced

HUSBAND of (or)

*Martin Szczepanik*

## 6 DATE OF BIRTH (month, day, and year)

*Mar. 30, 1901*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*20**11**24*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

*037*

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

*Mississippi*

## 10 NAME OF FATHER

*Nicholas Chess*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Poland*

## 12 MAIDEN NAME OF MOTHER

*Julia Mazoni*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Poland*

## 14

Informant (Address)

*Martin Szczepanik 411 S. Anne St.*

## 15

*Robert P. Harrison,*

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 24 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Mar. 7 1922* to *Mar 24 1922*that I last saw her alive on *Mar 24 1922*and that death occurred, on the date stated above, at *7:35 a.m.*

The CAUSE OF DEATH\* was as follows:

*Pregnancy - Placenta Praevia*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

*Puerperal Septicemia*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

*411 S. Anne St.*

Did an operation precede death?

*No* Date of

Was there an autopsy?

*No*

What test confirmed diagnosis?

*Clinical examination*

(Signed)

*Stanley W. M. D.*

, 19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVING

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

*John M. Weber**March 27 1922**1803 Bank*

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AR 25 1922

D 62767

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62767

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 12 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Boulden(a) RESIDENCE. No. 409 Faucett St. ST.  WARD. 

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown6 DATE OF BIRTH (month, day, year) Mar 23 18447 AGE 62 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland10 NAME OF FATHER John Boulden11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)14 Informant Hospital Records, (Address) Municipal Hospital.15 Robert P. Harrison, RegistrarPermit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 192217 I HEREBY CERTIFY, That I attended deceased from March 18, 1922, to March 23, 1922, that I last saw him alive on March 22, 1922, and that death occurred, on the date stated above, at 9:35 AM. The CAUSE OF DEATH\* was as follows:Pulmonary tuberculosis; 10 yrs  
Syphilis 30 yrs.  
(duration) yrs. mos. ds.CONTRIBUTORY Myocardial Infarct.  
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde McNeil M. D.3/24/1922 Address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn DATE OF BURIAL 3/25 192220 UNDERTAKER William Costello ADDRESS 502 E North

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 25 1922

D 62768

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_ ST. \_\_\_\_\_ WARD \_\_\_\_\_)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. \_\_\_\_\_ St. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

F.

## 4-COLOR OR RACE

W.

## 5-SINGLE,

MARRIED, S.  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH

March 26, 1920  
(Month) (Day) (Year)

## 7-AGE

2

If LESS than 1 day,

...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,  
(State or Country)

## 10-NAME OF FATHER

11-BIRTHPLACE OF FATHER  
(State or Country)

## 12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country)

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

MAR 25 1922

Robert F. Harrison,

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

March 24, 1922  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from March 17, 1922, to March 24, 1922, that I saw her alive on March 24, 1922, and that death occurred, on the date stated above, at 2:00 p.m.

The CAUSE OF DEATH\* was as follows:

Myocardial insufficiency

CONTRIBUTORY  
(Secondary)

(Signed) A. C. Harrison, M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted if not at place of death? 404 Harford

Former or usual residence 404 Harford Rd

## 19-PLACE OF BURIAL OR REMOVAL

Catholic Church

## DATE OF BURIAL

3/28, 1922

## 20-UNDERTAKER

William [unclear]

## ADDRESS

502 E North

N. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.



## Remarks

*Erysipela due to broncho pneumonia No infection prior*

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

*lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

<i>Abortion,</i>	<i>Cellulitis,</i>	<i>Childbirth,</i>	<i>Convulsions,</i>
<i>Hæmorrhage,</i>	<i>Gastritis,</i>	<i>Erysipelas,</i>	<i>Meningitis,</i>
<i>Gangrene,</i>	<i>Miscarriage,</i>	<i>Necrosis,</i>	<i>Peritonitis,</i>
<i>Phlebitis,</i>	<i>Pyæmia,</i>	<i>Septicæmia,</i>	<i>Tetanus.</i>

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (if induced), whether death is directly or indirectly due to the same.

N. B. - WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD. Every statement of information should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. - 1-10-21 - M & T - 1500 Bks.

# HEALTH DEPARTMENT - CITY OF BALTIMORE

D 62769

## CERTIFICATE OF DEATH.

D 62769

### 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1737 N. Chester ST. 8 WARD

### 2-FULL NAME

(a) RESIDENCE No. 1737 N. Chester ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

How long in U. S., if of foreign birth? 50 yrs. mos. ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant

(Address)

15

19

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY That I attended deceased from

March 20, 1922, to March 24, 1922,

that I last saw him alive on March 24, 19

and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

CONTRIBUTORY (Secondary)

(duration) 6 yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chronic findings

(Signed) Dariusz Kulesz M. D.

, 19 (Address) 1506 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

MAR 25 1922

Burial Permit Clerk

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 62770

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 948 N Lexington ST., 18 WARD)

2-FULL NAME

Dorothy R. Parish

(a) RESIDENCE NO.

748 W. Lee

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

1 yrs. 3 mos. 3 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec. 21, 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

3

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Enoch Parish

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Bessie Wolff

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant

(Address)

Enoch Parish 948 N. Lexington St.

15

MAR 25 1922

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/24/22

17

I HEREBY CERTIFY, That I attended deceased from

3/19/22, 19 to 3/24/22, 19

that I last saw him alive on 3/24/22, 19

and that death occurred, on the date stated above, at 11 AM

The CAUSE OF DEATH\* was as follows:

Tuberculosis

(duration) yrs. mos. 6 ds.?

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood

(Signed)

Samuel J. King

M. D.

3/24, 1922 (Address) 910 N. Lexington

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

St. Olivet

George J. Smith

DATE OF BURIAL

3/25/22

ADDRESS

1000 W. Lexington

D 62771

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62771

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1421

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1421

St., yrs., mos., ds.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

(Month) (Day) (Year)

7-AGE,

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER,

(State or Country).

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER,

(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert F. Harrison,

Filed

191

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic Intestinal myeloma

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Coroner)

524, 212 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.



D 62772

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62772

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

ST.

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of

WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

Filed

Robt 191 P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 17, 1922, to March 22, 1922,

that I last saw him alive on March 21, 1922,

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH\* was as follows:

Pleurisy

under my care

(duration)

yrs.

mos.

ds.

CONTRIBUTORY

(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? only physical exam.

(Signed)

Wm. A. Harris

M. D.

3/23, 1922 Address) 1200 Penn. Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

19

St. Zion Cemetery

578

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 25 1922

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Not tuberculous.*  
*No pneumonia. No*  
*further history.*

18.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62773

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62773

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Pronounced dead at*

City of BALTIMORE: (No. *Franklin Street* *Hwy 19* Ward)

2-FULL NAME *Eugene Prellman*

(Residence in Baltimore: No. *402 4* *Elmer* St.; yrs. *10* mos. *10* ds.)

Registered No. C.....

(If death occurred to a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *Color* 5-Single, Married, Widowed, or Divorced, *Single* (Write the word.)

6-DATE OF BIRTH, *unknown* 1885 (Month) (Day) (Year)

7-AGE, *37* If LESS than 1 day, *unknown* yrs. mos. ds. hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Carber* (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Sykesville Md*

10-NAME OF FATHER, *Henry Prellman*

11-BIRTHPLACE OF FATHER, (State or Country), *Md*

12-MAIDEN NAME OF MOTHER, *Ann Phillips*

13-BIRTHPLACE OF MOTHER, (State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Martha Lee*

(Address) *709 N Franklin St*

15- *Robert P. Harrison* 192 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *March 22* 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH\* was as follows: *Bullet wound through the heart* *Murder* (Duration) *instant* yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) *1* yrs. mos. ds.

(Signed) *James M. Penland* M. D. (Coroner.) *Mar 14 1922* (Address) *Good E. Ches*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, *1* yrs. *10* mos. *10* ds. In the State, *1* yrs. *10* mos. *10* ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Sykesville Md* DATE OF BURIAL, *3/26/22*

20-UNDERTAKER, *Paul H. Hensley* ADDRESS, *57th*

D 62774

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 D 62774

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 746 N Lexington ST., 21 WARD)

## 2-FULL NAME

William Siemer

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1233 Columbia Ave ST.,

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower5a ~~Married~~ widowed, or divorced HUSBAND of Minnie Siemer6 DATE OF BIRTH (month, day, and year) Oct 16 18367 AGE Years 85 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 1886(b) General nature of industry, business, or establishment in which employed (or employer) Box Mfr.

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Germany.

## 10 NAME OF FATHER

not known

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

not known

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany.

## 14

Informant (Address)

William H. Siemer  
1137 7th Hamburg St.

## 15

, 19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1922

17

I HEREBY CERTIFY, That I attended deceased from March 1922 to March 23, 1922that I last saw him alive on March 22, 1922and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH\* was as follows:

Chronic Endocarditis

## CONTRIBUTORY (Secondary)

(duration) 2 yrs. — mos. — ds.(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

Geo. H. Siemer M. D.March 24, 1922 (Address) 800 Harlem Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

David Hill Park3-25-22

## 20 UNDERTAKER

## ADDRESS

Mr. Chas. A. G. Rohde 600 Lexington

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

MAR 25 1922



B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62775 HEALTH DEPARTMENT—CITY OF BALTIMORE 164 D 62775

1-PLACE OF DEATH  
City of BALTIMORE: (No. *Monument Brick Yard*, St. *14th* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
2-FULL NAME *Alley Stewart*  
(Residence in Baltimore: No. *2128* York, St. *78* yrs., *10* mos., *10* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Married*  
6-DATE OF BIRTH *June 19* 18*93*  
(Month) (Day) (Year)  
7-AGE *78* yrs., *10* mos., *10* ds. If LESS than 1 day, hrs. nr. min.?  
8-OCCUPATION:  
(a) Trade, profession, or particular kind of work *Chief Builder*  
(b) General nature of industry, business, or establishment in which employed (or employer) *616*  
9-BIRTHPLACE, (State or Country), *Balto Md*  
10-NAME OF FATHER, *William Glenn*  
11-BIRTHPLACE OF FATHER, (State or Country), *Md*  
12-MAIDEN NAME OF MOTHER, *Frances Hickland*  
13-BIRTHPLACE OF MOTHER, (State or Country), *Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Sgt E Herbert Glenn*  
(Address) *Hamilton Md.*

15-

Robert P. Harrison,

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *Mar 23/22*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
*Security Exposure Shock*

CONTRIBUTORY (Secondary)

(Signed) *G. S. C. Blair* (Coroner.)  
Address *1436 Bray*  
\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).  
At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Balto Cem.*

*3-25-22*

20-UNDERTAKER

ADDRESS

*ETB Harle*

*115 E West St*

MAR 25 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62776

## CERTIFICATE OF DEATH.

129 D 62776

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No.

## 2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

12 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If nonresident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 1869

7 AGE

53

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md 40 year. md

10 NAME OF FATHER

Henry Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Nancy Branch

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

## PARENTS

14 Informant (Address)

Henry Martin, Jr. 807 Druid Hill Ave

15 Filed

5 1922

19

Robert P. Earlston,

Registrar

Barthel Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 24 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 22 1922 to March 24 1922

that I last saw him alive on March 24 1922

and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH\* was as follows:

Nephritis + Endocarditis

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John E. Gassner M. D.

, 19 (Address) 753 E. 3rd St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathartum Cemetery

March 25 1922

20 UNDERTAKER

ADDRESS

John H. Toddman

1424 Hill St

D 62777

Spec. 6-9-19—H. P. Co.—1000 Hks.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62777

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 Harford Ave ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Philip Smith

## (a) RESIDENCE. NO.

709 Harford Ave ST.

WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if of foreign birth? Lifetime mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

m

4 COLOR OR RACE

B

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Married Husband

6 DATE OF BIRTH (month, day, and year)

Don't know 1873

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

49

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Va Lynchburg Va

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant

Bell Smith

(Address)

709 Harford Ave

15

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 22 1922

17

HEREBY CERTIFY, That I attended deceased from

Feb 25 1922 to March 22 1922that I last saw him alive on March 22 1922

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Brifpe(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

Acute Broncho Pneumonia(duration) yrs. mos. 10 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

Physical(Signed) J. H. Hornsby M. D.3/22 1922 (Address) 733 Lexington St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laural CemeteryMarch 26 1922

20 UNDERTAKER

ADDRESS

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state name and address of hospital or institution where death occurred. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62778

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 East 41st.St.

ST.:

WARD)

## 2-FULL NAME Mary Angela Cook.

(a) RESIDENCE. NO. 609 E. 41st.St.

(Usual place of abode)

ST.:

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXXX

6 DATE OF BIRTH (month, day, and year) ? ? 1877

7 AGE Years 45 Months ? Days ? If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Chambersburg (State or country) Pa.

10 NAME OF FATHER Samuel Cook

11 BIRTHPLACE OF FATHER (city or town) Chambersburg (State or country) Pa.

12 MAIDEN NAME OF MOTHER Annie Harway

13 BIRTHPLACE OF MOTHER (city or town) Chambersburg (State or country) Pa.

14 Informant Florina Remington (Address) 609 E 41st St

15 Filed Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar. 9, 1922, to Mar. 23, 1922, that I last saw her alive on March 23rd, 1922, and that death occurred, on the date stated above, at 6.30 P. m. The CAUSE OF DEATH\* was as follows:

Cardiac Syncope

about 2 1/2 hrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Carcinoma of Colon.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Radiographs (Signed) G. Labate Ewall, M. D.

3/24, 1922 (Address) 905 K. Silver St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral Cemetery Apr 27 1922

20 UNDERTAKER

H. E. Hughes 424 N. Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MAR 25 1922

Burial Permit Clerk



B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

154673  
D 62779

HEALTH DEPARTMENT—CITY OF BALTIMORE D 62779

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Charles Muestner alto. 4 ft.

(a) RESIDENCE NO.

519 S. Collington West ST.,

WARD

(Usual place of abode)

Unknown

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of

WIFE of

Mrs. Hattie Schumann  
4610 Easton Ave.

6 DATE OF BIRTH (month, day, and year)

Dec. 29, 1870

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

51

9

22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore  
Md.

10 NAME OF FATHER

John Michael Muestner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Barbara Hower

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

JOHNS HOPKINS HOSPITAL  
Baltimore

15

Robert P. Bartlett

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23, 1922

17

I HEREBY CERTIFY, That I attended deceased from March 22, 1922, to March 23, 1922, that I last saw him alive on March 22, 1922, and that death occurred, on the date stated above, at 2:27 p.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death?

No Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

None

(Signed)

John L. Dorsey

M. D.

19 (Address)

J.H.H.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Baltimore Cemetery March 25, 1922

20 UNDERTAKER

ADDRESS

H. Sander & Sons 1210 Fleet St.

APR 25 1922

D 62780

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

45 D 62780

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *615 N. Potomac* ST., *7* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Mary Karrer*

## (a) RESIDENCE NO.

*615 N. Potomac*

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *April 27, 1862*7 AGE Years *59* Months *10* Days *26* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *At home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *M. d.*10 NAME OF FATHER *Gottfried Karrer*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Not known*13 BIRTHPLACE OF MOTHER (city or town) *Not known* (State or country)14 Informant *Albert Karrer* (Address) *615 N. Potomac St.*15 *Roberts P. Harrison* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 28, 1922*17 I HEREBY CERTIFY, That I attended deceased from *Feb. 19, 1921*, to *March 23, 1922*, that I last saw *her* alive on *March 23, 1922*and that death occurred, on the date stated above, at *12:50 P. M.*

The CAUSE OF DEATH\* was as follows:

*Rectal Carcinoma*(duration) yrs. *14* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *✓*

Was there an autopsy?

What test confirmed diagnosis? *Clinical*(Signed) *Geo. Heller* M. D.325. 1922 Address) *1937 Gough St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Oak Lawn Cemetery**March 28, 1922*

20 UNDERTAKER

ADDRESS

*H. Vandergriff Sons 1710 E. Mt. St.*

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

MAR 25 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62781

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

ST.: 10 WARD)

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

20 yrs. mos. ds.

ST.

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? 30 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrn. or min.

46

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14 Informant (Address)

J. Henry 1429 E. Baltimore St.

15 Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 19 22

17

I HEREBY CERTIFY, That I attended deceased from March 23, 19 22, to March 24, 19 22.

that I last saw him alive on March 23, 19 22, at 8 P. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Intestinal Obstruction.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

Mesenteric Thrombosis

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

At home

Did an operation precede death?

Yes

Date of

March 23, 19 22

Was there an autopsy?

No

What test confirmed diagnosis?

Operation

(Signed)

3/27/22 (Address)

227 E. Baltimore St. Hebrew Hospital

\*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

Hebrew Hebrew Burial

ADDRESS

Jas. Lewis

3-26-1922

1429 E. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

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Baltimore, Md., March 31, 1922.

I do hereby make oath that the date of death of deceased, Mr. Morris Shapiro, given on Baltimore City Department of Health Death Certificate D-62781, as 68 years is not correct; same should be recorded as 46 years.

Jack Lewis

Subscribed and sworn to before me this 31st day of March, 1922.

Reed Gaither  
Notary Public.

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mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-  
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.  
TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62782

CERTIFICATE OF DEATH.

113 D 62782

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 N. Catherine St. ST. 20 WARD)

2-FULL NAME

William Wilbur Coarts

(a) RESIDENCE NO.

9 N. Catherine St.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 23<sup>rd</sup> 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Charles R. Coarts

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Clara Winkel

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Charles R. Coarts 9 N. Catherine St.

Robert F. Harrison,

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 24<sup>th</sup> 19 22

17

I HEREBY CERTIFY, That I attended deceased from March 20, 19 22 to March 24, 19 22, that I last saw him alive on March 24, 19 22, and that death occurred, on the date stated above, at 5 A. M.

The CAUSE OF DEATH\* was as follows:

Gastro Enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Mar. 24<sup>th</sup> 19 22

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL

20 UNDERTAKER

ADDRESS

Joseph A. Coats

1003 N. E. St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62783

D 62783

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1101 Woodley ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Eugene Keimble(a) RESIDENCE. NO. 1101 Woodley ST.: 16 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of none6 DATE OF BIRTH (month, day, and year) March 6 - 19197 AGE Years 3 Months 17 Days 17 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City (State or country)10 NAME OF FATHER Andrew Keimble11 BIRTHPLACE OF FATHER (city or town) Baltimore City (State or country)12 MAIDEN NAME OF MOTHER Margaret Mallison13 BIRTHPLACE OF MOTHER (city or town) Baltimore City (State or country)

14

Informant Andrew Keimble (Address) 1101 Woodley St

15

MAR 25 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 23 192217 I HEREBY CERTIFY, That I attended deceased from Mar 2, 1922 to Mar 23, 1922 that I last saw him alive on March 22, 1922 and that death occurred, on the date stated above, at 9:55am.

The CAUSE OF DEATH\* was as follows:

acute follicular tonsillitis  
16 days.CONTRIBUTION (duration) yrs. mos. ds. Secondary 16 ds. Home

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of noneWas there an autopsy? noWhat test confirmed diagnosis? clinical symptoms(Signed) Chas A Fetherhoff, M. D., 19 (Address) 1807 W North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Olivet Cem March 27 1922

20 UNDERTAKER

ADDRESS

Martin Lakey & Sons 1839 W North

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62784

D 62784

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Bon Secours Hospital* ST.;

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*Bro. Louis Becker S.M.*(Residence in Baltimore: No. *29 N. Fulton Ave.*St.; *29* yrs., — mos. — ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE,

*White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

## 6-DATE OF BIRTH,

....., *1863*.  
(Month) (Day) (Year)

## 7-AGE,

*59* yrs. .... mos. .... ds.

If LESS than 1 day,

.... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

*Teacher 068*  
*Class Work Education*

## 9-BIRTHPLACE, (State or Country),

*Ohio*  
*Columbus, Ohio*

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER (State or Country),

*Germany*

## 12-MAIDEN NAME OF MOTHER

*do not know*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*do not know*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

*George L. Ebert**29 N. Fulton Ave*

## 15-

*Robert P. Harrison*

Regist.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*March 25, 1922*.  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Mar. 24 1922, to Mar. 25 1922*that I saw him alive on *Mar. 24 1922*,and that death occurred, on the date stated above, at *25* m.

The CAUSE OF DEATH\* was as follows:

*apoplexy*  
*Cerebrovascular Hypertension*

..... (Duration) ..... yrs. .... mos. .... ds.

## CONTRIBUTORY (Secondary)

..... (Duration) ..... yrs. .... mos. .... ds.

(Signed) *S. Lloyd Johnson* M. D.*Mar. 25, 1922* (Address) *Bon Secours Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? *at home*Former or usual residence *29 N. Fulton Ave*

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL.

*Dayton Ohio**Feb. 26, 1922*

## 20-UNDERTAKER

## ADDRESS

*George Stanley Fulton**Dayton*

WRITE FULL NAME OF PHYSICIAN, PHYSICIANS, HOSPITAL, OR OTHER PLACE OF DEATH, IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION, IF KNOWN, IS IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

AR 2 54922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62785

D 62785

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 136 N. Harr St. ST., 6 WARD)

## 2. FULL NAME

Thomas Leo. Sessa.

## (a) RESIDENCE NO.

136 N. Harr St. ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

MaleWhiteSingle5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 19-1922

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore  
md.

10 NAME OF FATHER

Sebastian Sessa11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Italy

12 MAIDEN NAME OF MOTHER

Angelo Ruggiero13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Italy

14

Informant  
(Address)Sebastian Sessa.  
136 N. Harr St.

15

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 24 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 19, 1922 to March 24, 1922

that I last saw him alive on

March 24, 1922and that death occurred, on the date stated above, at 6:00 P. m.

The CAUSE OF DEATH\* was as follows:

Atelectasis(duration) yrs. mos. 5 ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

E. L. Sessa, Jr. M. D.

3.25.22.

19 (Address)

Den Hill

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Redeemer Ch.

20 UNDERTAKER

Lilly & Zeller.

DATE OF BURIAL

Mich 25 1922

ADDRESS

403 S. M. St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. See instructions on back of certificates.

MAR 25 1922

Burial Permit Clerk





## HEALTH DEPARTMENT—CITY OF BALTIMORE

15652  
D 62787

## CERTIFICATE OF DEATH.

15652 D 62787

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 25 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Miss Myrtle Strauss

## (a) RESIDENCE NO.

66 Wilhelm

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 3 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

FemaleWhiteMarried

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofJohn H. Strauss

## 6 DATE OF BIRTH (month, day, and year)

1897-Dec-22

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.24 years3—

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

## 10 NAME OF FATHER

Walter J. Cole

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

## 12 MAIDEN NAME OF MOTHER

Berdie McVetrick

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Indiana

## 14

Informant  
(Address)JOHNS HOPKINS HOSPITAL  
Records

## 15

Informant  
(Address)Robert P. Harrison

, 19

Burial Permit Clerk.

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 22nd 1922

## 17

I HEREBY CERTIFY, That I attended deceased from March 21st 1922 to March 22nd 1922.  
that I last saw her alive on March 22nd 1922  
and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH\* was as follows:

Menigitis -

(duration)

yrs.

mos.

3 ds.

## CONTRIBUTORY (Secondary)

sinus infection

(duration)

yrs.

mos.

10 ds.

## 18 Where was disease contracted

if not at place of death?

66 Wilhelm St.

## Did an operation precede death?

yes Date of 3/21

## Was there an autopsy?

## What test confirmed diagnosis?

(Signed)

E. Charles Andrews

M. D.

, 19

(Address)

Johns Hopkins Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Linden Park Cemetery Mar 25 1922

## 20 UNDERTAKER

## ADDRESS

H.B. Vesper 2236 Frank

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MAR 25 1922

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name organ; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Staphylococcus meningitis  
non-epidemic. Operation  
for sinus trouble*





D 62789

## HEALTH DEPARTMENT—CITY OF BALTIMORE, 001

## CERTIFICATE OF DEATH.

D 62789

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2438 Ashland Ave) ST. 7

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E Beck

(a) RESIDENCE. No. 2438 Ashland Ave ST. 7

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Beck

6 DATE OF BIRTH (month, day, and year) Feb 23/1854

7 AGE Years 68 Months 1 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore State or country) Md

10 NAME OF FATHER John Roach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) German

14 Informant (Address) Amelia Myers 1207 N. Lexington Ave

15 Filed Robert P. Harrison, Registrar

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1922, to Mar 22, 1922, that I last saw him alive on Mar 22, 1922, and that death occurred, on the date stated above, at 9:30 A.M. The CAUSE OF DEATH\* was as follows:

Myocarditis  
Tuberculosis  
(duration) yrs. mos. ds.  
CONTRIBUTORY Chronic Nephritis - Arteriosclerosis  
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptomatic  
Signed: Albert B. Harrison, M.D.

3/24/22 (Address) 718 N. Patterson Pl

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER 37th Street  
Wendell H. H. & Son

AR 25 1922

D 62790

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62790

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *819 N. Eden* ST., *10* WARD)

## 2-FULL NAME

*Philip C. Galster*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

*819 N. Eden*ST., *10* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *68* yrs. *4* mos. *0* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

## 5a If married, widowed, or divorced

HUSBAND (or) WIFE

*Amelia Galster*

## 6 DATE OF BIRTH (month, day, and year)

*Dec. 1853*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*68**4*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Book keeper*

(b) General nature of industry, business, or establishment in which employed (or employer)

*008*

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*

## 10 NAME OF FATHER

*Frederick Galster*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Baltimore Md.*

## 12 MAIDEN NAME OF MOTHER

*Unknown*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant

(Address)

*Amelia Galster*  
*819 N. Eden St.*

## 15

*Robert P. Harrison,*

19

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 24 1922*17 I HEREBY CERTIFY that I attended deceased from *March 15 1922* to *March 24 1922*that I last saw him alive on *March 24 1922*and that death occurred, on the date stated above, at *1235 P. m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Nephritis**Chronic* (duration) *3* yrs. *1* mo. *0* ds.

CONTRIBUTORY (Secondary)

(duration) *2* yrs. *0* mo. *0* ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*What test confirmed diagnosis? *Clinical*  
*Stable H. A. Meyer* M. D.  
*3/24 1922* (Address) *1031 N. Caroline St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Lansden Park Cem.**March 27 1922*

20 UNDERTAKER

ADDRESS

*Frank A. Fink**915 N. Gay St.*

N. B.—WRITE PLAINLY, WITHOUT FADING INK—THIS STATEMENT SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AR 25 1922

WRITE PLAINLY, WITH UNFADING INK.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

62791 HEALTH DEPARTMENT—CITY OF BALTIMORE 62791  
D 62791 CERTIFICATE OF DEATH 74-001 D 62791  
PLACE OF DEATH REGISTERED NO. C

CITY OF BALTIMORE (No. 750 N. North Ave. ST. 13 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
2-FULL NAME Isaac Newton Allen  
(Residence in Baltimore: No. 750 N. North Ave. St. 2 yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widowed
6 DATE OF BIRTH Dec 29, 1832 (Month) (Day) (Year)		
7 AGE 89 yrs. 2 mos. 25 ds. IF LESS than 1 day, — hrs. or — min.?		
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) retired job		
9 BIRTHPLACE (State or country) New Jersey		
PARENTS	10 NAME OF FATHER Captain Allen	
	11 BIRTHPLACE OF FATHER (State or country) Unknown	
	12 MAIDEN NAME OF MOTHER "	
	13 BIRTHPLACE OF MOTHER (State or country) "	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sallie E. Condon  
(Address) 750 N. North Ave.

15

MAR 26 1922

ROBERT R. KRAVICH

191 Social Pathologist

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10 DATE OF DEATH  
March 24, 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15, 1922, to March 24, 1922, that I saw him alive on March 24, 1922, and that death occurred, on the date stated above, at 2 P. m. The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 10 ds.  
Contributory (SECONDARY) Hypostatic Congestion  
(Duration) yrs. mos. 5 ds.  
(Signed) Vernon H. Condon M. D.  
(Address) 750 N. North Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.  
Where was disease contracted, if not at place of death?  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
Bridgeton, N. J. March 27, 1922  
20 UNDERTAKER ADDRESS  
John Mitchell 1201 N. Taylor

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

62792 HEALTH DEPARTMENT—CITY OF BALTIMORE 62792  
D 62792 CERTIFICATE OF DEATH 1922 D 62792  
1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Senior Hospital St. 15 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
2-FULL NAME George Green  
(Residence in Baltimore: No. 1367 N Cary St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE Colored 5-Single, Married, Widowed, or Divorced. Single  
6-DATE OF BIRTH June 6, 1887  
7-AGE 34 yrs. 9 mos. 17 ds. If LESS than 1 day, hrs. or min.?  
8-OCCUPATION:  
(a) Trade, profession, or particular kind of work waiter 086  
(b) General nature of industry, business, or establishment in which employed (or employer) Lunch Room

9-BIRTHPLACE (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Green  
(Address) 2015 N. Cullough St.

15-

MAR 26 1922

ROBERT R. KRAUTER,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH March 23, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Bullet wound through abdomen murder

CONTRIBUTORY (Secondary) Peritonitis & Septicemia  
(Duration) yrs. mos. ds.

(Signed) James M. Houston M. D.  
(Coroner.)

Mar 25 1922 (Address) 700 E. Chase St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents.)  
At place Franklin Senior Hospital In the yrs. mos. ds.  
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

1367 N Cary St  
Former or usual residence 1367 N Cary St

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

St. O'Connell Cemetery Mar 26, 1922

20-UNDERTAKER, ADDRESS

George H. Hollan 1631 Broad Hill Ave



N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

62793 HEALTH DEPARTMENT—CITY OF BALTIMORE  
D 62793 CERTIFICATE OF DEATH.

62793  
10 D 62793  
REGISTERED NO.

1. PLACE OF DEATH

CITY OF BALTIMORE, (No. 7007 Ashland Ave ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Ellsworth W. Mayhorne

(a) RESIDENCE NO.

7007 Ashland Ave

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Widowed

6 DATE OF BIRTH (month, day, and year)

Aug 8, 1917

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4

7

17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Davis Mayhorne

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Theresa Kanow

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Davis Mayhorne 7007 Ashland Ave

15

MAR 26 1922 ROBERT R. KRASER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25 1922

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1922, to March 25, 1922, that I last saw him alive on March 25, 1922, and that death occurred, on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH\* was as follows:

Siphilitic

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Signed) M. J. Page M. D. 3/25, 1922 Address) 709 N B Dway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

INTERMENT

20 UNDERTAKER

Geo. M. Fink & Son

DATE OF BURIAL

Mar 26 1922

ADDRESS

Geo. M. Fink & Son

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62794

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 Light

2-FULL NAME

(a) RESIDENCE. No. 311 E. Hamburg

Length of residence in city or town where death occurred

yrs. 2 mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST.

WARD.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1922, to March 25, 1922, that I last saw him alive on March 25, 1922, and that death occurred, on the date stated above, at 10:45 A. m. The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 ~~Single~~ Married Widowed.

Male

White

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAR 26 1922

ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62795

## CERTIFICATE OF DEATH.

90 D 62795

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

30 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

20 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1800

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

102

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State, or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

J. Lewis, 1439 E. Balt. St.

15

Filed

MAR 26 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1922

17

I HEREBY CERTIFY, That I attended deceased from March 23, 1922, to March 25, 1922, that I last saw him alive on March 25, 1922,

and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH\* was as follows:

Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

3/26, 1922 (Address)

Clinical  
W. J. Bayliss M. D.  
210 N. E. Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

Mt. Carmel

Jack Lewis,

DATE OF BURIAL

3-26 1922

ADDRESS

1439 E. Balt.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state  
tion should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-  
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62796

## CERTIFICATE OF DEATH.

179 D 62796

1-PLACE OF DEATH

St Agnes Hosp

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

CITY OF BALTIMORE: (No.

ST.,

WARD)

2-FULL NAME

Miss Anna Warner.

(a) RESIDENCE NO.

209 W. Franklin St.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

4 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)

Female. White

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

unknown

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

60 yrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Handwork.

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

086

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Not Known

10 NAME OF FATHER

Not Known

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

unknown

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

unknown

14

Informant  
(Address)

Anna C. Burch  
831 Park Ave

15

File

MAR 26 1922 ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3-25-1922

17

I HEREBY CERTIFY, That I attended deceased from

March 21, 1922, to March 25, 1922,

that I last saw him alive on 3-25-1922,

and that death occurred, on the date stated above, at 8:30 p. m.

The CAUSE OF DEATH\* was as follows:

Arterio-sclerosis, Hypertension

Chronic nephritis  
Apoplexy (4 days)

5 yrs. duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

Pulmonary edema (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. M. D.

, 19 (Address) St Agnes Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Cathedral

DATE OF BURIAL

3/27 1922

20 UNDERTAKER

William Cook

ADDRESS

502 E. North





## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62798

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 3418 Belair Road ST., WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, Divorced (write the word)

6a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAR 26 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 30, 1922, to March 24, 1922.

that I last saw him alive on March 24, 1922.

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) C. H. Burdick, M. D.

March 25 1922 (Address) 8 B Patterson Park

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS IMPORTANT. AGE should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ST Burdick

8 B. Patterson Park

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 6-9-13-H. P. Co.-1000 Bks.

Moody, ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62799

153 D 62799

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_ ST.: \_\_\_\_\_ WARD) \_\_\_\_\_

2-FULL NAME

(a) RESIDENCE. NO. \_\_\_\_\_ ST.: \_\_\_\_\_ WARD. \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

5

mos.

ds.

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX \_\_\_\_\_ 4 COLOR OR RACE \_\_\_\_\_ 5 Single, Married, Widowed, or Divorced (write the word) \_\_\_\_\_

5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) \_\_\_\_\_

7 AGE

Years

Months

Days

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

20

10

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work \_\_\_\_\_

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) \_\_\_\_\_ (State or country) \_\_\_\_\_

10 NAME OF FATHER \_\_\_\_\_

11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_ (State or country) \_\_\_\_\_

12 MAIDEN NAME OF MOTHER \_\_\_\_\_

13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_ (State or country) \_\_\_\_\_

14

Informant (Address) \_\_\_\_\_

15

MAR 26 1922

ROBERT K. KRAUTER, Registrar  
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) \_\_\_\_\_

17

I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_ that I last saw him alive on \_\_\_\_\_

and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Inguinal Abscess (Left Groin)

CONTRIBUTORY (Secondary) \_\_\_\_\_

18 Where was disease contracted if not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

(Signed) \_\_\_\_\_

, 19 \_\_\_\_\_

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL \_\_\_\_\_

DATE OF BURIAL \_\_\_\_\_

20 UNDERTAKER \_\_\_\_\_

ADDRESS \_\_\_\_\_

D 62800 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62800

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3437 Roland Ave. ST. 13 WARD)

## 2-FULL NAME

Samuel Hoover

(a) RESIDENCE. No. 3437 Roland Ave. ST. 13 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Hoover

6 DATE OF BIRTH (month, day, and year) Aug. 5-1852

7 AGE Years 69 Months 7 Days 19 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Shoe-maker

(b) General nature of industry, business, or establishment in which employed (or employer)

088

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Co. Maryland

10 NAME OF FATHER

Phillip Hoover

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary Hampshire

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Co. Maryland

## 14

Informant (Address)

Miss Francis V. Hoover 3437 Roland Ave.

## 15

Filed

MAR 26 1922

ROBERT E. KRAUTER

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 14, 1922, to March 24, 1922.

that I last saw him alive on March 24, 1922.

and that death occurred, on the date stated above, at 9.30 A. M.

The CAUSE OF DEATH\* was as follows:

Apoplexy.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

Chronic interstitial nephritis (duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. J. Daner, M. D.

25, 1922 (Address) 800 W 33rd St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Tabor Cem. Hoffmanville March 27 1922

20 UNDERTAKER

Horace H. Surgee 3631 Kell Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62801

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore, No.

33 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR (OR RACE)

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

6-DATE OF BIRTH,

June 6, 1848

7-AGE,

73 yrs. 9 mos. 19 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Carpenter 1015  
Retired 2 years

9-BIRTHPLACE.

(State or Country).

Balto. Co. Md.

10-NAME OF FATHER

Jacob M. Gosnell

11-BIRTHPLACE OF FATHER

(State or Country).

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country).

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs. Martha D. Gosnell  
1047 Falls Road

15-

MAR 26 1922

ROBERT R. KRAUTER,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 25, 1922

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest

thereon and from the evidence obtained by said inquest

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH was as follows:

Ischaemic disease of heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. [Signature] M. D.

(Coroner) 3682 Roland

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Grundy Ridge

March 28 1922

20-UNDERTAKER

ADDRESS

Horace H. Burgee

363 Falls Rd

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 62802

## CERTIFICATE OF DEATH.

D 62802 DEATH

CITY OF BALTIMORE: (No. 910 W Linwood Ave. 1 WARD)

2-FULL NAME Virginia May Holthaus,

(a) RESIDENCE NO. 910 W Linwood Ave. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 22, 1918

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
2 3 3

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

MAR 26 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25 1922

17

I HEREBY CERTIFY, That I attended deceased from March 14, 1922, to March 25, 1922, that I last saw her alive on March 24, 1922, and that death occurred, on the date stated above, at 2:10 P.M.

The CAUSE OF DEATH\* was as follows:

Pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 11 ds.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wound

(Signed)

19 (Address) 1257 Potomac

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

H. Sander &amp; Sons 1715 Thut St

N. B.—WRITE PLAINLY, WITH CARE. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name organ; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN,

*No infectious disease*

N. B.—WRITE PLAINLY, WITH CARE. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D 62803

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62803

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 646 W. Mulberry ST. 17 WARD)

2-FULL NAME

Sarah, R. Glick

(a) RESIDENCE NO.

646 W. Mulberry

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. — mos. — ds. How long in U. S., if of foreign birth? 21 yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

75

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Morris Glick

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Victoria Glick

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Morris Glick  
900 Warner St

15

ROBERT R. KRAUTER  
Registrar  
Burial Permit Clerk.

MAR 26 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25 1922

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1922, to March 25, 1922, that I last saw her alive on March 25, 1922, and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH\* was as follows:

Congestion of lungs

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

Chronic Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Chemical

(Signed) Harry L. Rogers M. D.

3/26/22 (Address) 1303 New Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Hebrew Washington Rd

3/26 1922

20 UNDERTAKER

ADDRESS 1127

S. Linnear & Bros

E Balto St



D 62804

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

25-001 D 62804

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2508 1/2 Biddle ST. 11 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. 2508 1/2 Biddle ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred: yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1922 to March 25, 1922 that I last saw him alive on March 24, 1922 and that death occurred, on the date stated above, at 12:00 P. M.

The CAUSE OF DEATH\* was as follows:

Bronchial Pneumonia

CONTRIBUTORY (Secondary)

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1922 Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MAR 26 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

r. Grounch 1174 Saratoga

William C. 502 E. Nat'l

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62805

## CERTIFICATE OF DEATH.

90 D 62805

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2321 Madison Ave ST., 13 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. 2321 Madison Ave ST., 13 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Kafka6 DATE OF BIRTH (month, day, and year) July 7-18527 AGE Years 69 Months 8 Days 18 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045(b) General nature of industry, business, or establishment in which employed (or employer) Furniture Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria10 NAME OF FATHER Morris Kafka11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria12 MAIDEN NAME OF MOTHER unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

## PARENTS

14 Informant J. Kafka (Address) 2321 Madison Ave

## 15

MAR 26 1922 ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25<sup>th</sup> 192217 I HEREBY CERTIFY That I attended deceased from March 12<sup>th</sup> 1922 to March 25<sup>th</sup> 1922 that I last saw him alive on March 20<sup>th</sup> 1922 and that death occurred, on the date stated above, at 343 Ave.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Hypostatic Pneumonia(duration) yrs. mos. ds. 4

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Samuel Rosenberg, M. D.3/25/1922 (Address) 2302 Madison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Bellevue Friendship Cem3/27/1922

20 UNDERTAKER

ADDRESS

David Sondheim 1180 Mt Royal Ave

N. B.—WRITE PLAINLY, WITH UNFRACTIONATED WORDS. PHYSICIANS SHOULD STATE EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 62806

62806

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 S. Ashmun ST., 18 WARD)2-FULL NAME Sarah D. Simmers(a) RESIDENCE NO. 119 S. Ashmun ST., 18 WARD  
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced  
HUSBAND of  
or) WIFE of Dec 22 1924

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
3 2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country)10 NAME OF FATHER Frank Simmers11 BIRTHPLACE OF FATHER (city or town) Ba  
(State or country)12 MAIDEN NAME OF MOTHER Effie Perry13 BIRTHPLACE OF MOTHER (city or town) Ba  
(State or country)14 Informant Frank Simmers  
(Address) 119 S. Ashmun15 MAR 27 1922 ROBERT R. KRAUTER,  
Burial Permit Clerk

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/24/2217 I HEREBY CERTIFY, That I attended deceased from 3/22/1922 to 3/24/1922that I last saw her alive on 3/24/22, 19and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH\* was as follows:

Jaundice(duration) 4 wks yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 1/2 ds.?18 Where was disease contracted  
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? usual(Signed) Bernard J. Gray M. D.3/24/1922 (Address) 910 W Lombard

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVALLondon Park

DATE OF BURIAL

Mar 27 1922

20 UNDERTAKER

ADDRESS

Wm. J. Fields 1200 N Lombard

N. B.—WRITE PLAINLY, WITH CLARITY. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62807

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1602 Cole St.* ST. *19* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *1602 Cole St.* St.: yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED *Single* (Write the word.)6-DATE OF BIRTH *March 5<sup>th</sup> 1922* (Month) (Day) (Year)7-AGE, *19* yrs. mos. ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work *Student*  
(b) General nature of industry, business, or establishment in which employed (or employer) *None*9-BIRTHPLACE (State or Country), *Baltimore Md*10-NAME OF FATHER *Frank R. Sullivan*11-BIRTHPLACE OF FATHER (State or Country), *Baltimore Md*12-MAIDEN'S NAME OF MOTHER *Anna C. Smith*13-BIRTHPLACE OF MOTHER (State or Country), *New York*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank R. Sullivan*(Address) *1602 Cole St.*

15-

MAR 27 1922 ROBERT R. KRAUTER, Registrar

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH *March 24<sup>th</sup> 1922* (Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *Mar 22 1922* to *Mar 24 1922*, that I saw him live on *Mar 24 1922* and that death occurred, on the date stated above, at *8:30 P.M.* The CAUSE OF DEATH\* was as follows:  
*Patent foramen ovale*  
*Cardiac disease*  
(Duration) *19* yrs. mos. ds.  
CONTRIBUTORY (Secondary) *Cardiac disease*  
(Duration) *19* yrs. mos. ds.  
(Signed) *Dr. J. H. K. K. K.* M. D.  
(Address) *1901 Eutaw Rd.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. *19* ds. In the State yrs. mos. *19* ds.Where was disease contracted, if not at place of death? *at place of death*Former or usual residence *1602 Cole St., City*19-PLACE OF BURIAL OR REMOVAL, *Baltimore* DATE OF BURIAL, *Mar 27, 1922*20-UNDERTAKER *John J. Fields 1200 N. Lombard* ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



D 62808

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62808

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1821 E. Lombard ST., V WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Walter Hayden

## (a) RESIDENCE NO.

1821 E. Lombard ST.,

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male White Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

## 6 DATE OF BIRTH (month, day, and year)

Feb 14 1917

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5111

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Child

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

## 10 NAME OF FATHER

Walter Hayden

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

## 12 MAIDEN NAME OF MOTHER

Catherine Deppel

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md.

## 14

Informant (Address)

Walter Hayden  
1821 E. Lombard St.

## 15

ROBERT R. KRAUTER, Registrar

MAR 27 1922

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Mar 16 1922 to Mar 25 1922that I last saw him alive on Mar 24 1922and that death occurred, on the date stated above, at 12:20 a m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia(duration) yrs. mos. 9 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Asthma

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical Signs(Signed) L. M. Barker M. D., 1922 (Address) 111 E. Harbor

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

Stendell Deppel & SonMar 27 1922  
37 S. Ann. St.

N. B.—WRITE PLAINLY, WITH CARE. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 62809 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: WARD)

## 2-FULL NAME

(a) RESIDENCE. No.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAR 27 1922

ROBERT A. KRAUTER, Registrar

Burial Permit

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Mar 16 1922, to Mar 25 1922

that I last saw him alive on Mar 25 1922.

and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH\* was as follows:

Bronchial pneumonia

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. R. P. M. D.

19 (Address) 40 S Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health ASSO.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior*

D 62810

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 243 S. Register ST. 2 WARD)

## 2-FULL NAME

(a) RESIDENCE. NO. 243 S. Register ST. 2 WARD. (If nonresident give city or town and State)  
(Usual place of abode)  
Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Sympkowiak6 DATE OF BIRTH (month, day, and year) Dec. 22, 18587 AGE Years 63 Months 3 Days 3 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer Unknown.9 BIRTHPLACE (city or town) (State or country) Poland.10 NAME OF FATHER Unknown.11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.12 MAIDEN NAME OF MOTHER Unknown.13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.14 Informant Thomas Sympkowiak  
(Address) 243 S. Register15 Filed MAR 27 1922 19 ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 192217 I HEREBY CERTIFY, That I attended deceased from March 15, 1922, to March 25, 1922, that I last saw him alive on March 25, 1922, and that death occurred, on the date stated above, at 5.10 P. m.  
The CAUSE OF DEATH\* was as follows:① Chronic interstitial nephritis  
② UremiaCONTRIBUTORY (Secondary) Bronchitis - pneumonia (duration) yrs. mos. ds. 10 ds.18 Where was disease contracted if not at place of death? Unknown.Did an operation precede death? No. Date ofWas there an autopsy? No.What test confirmed diagnosis? Examination of urine  
(Signed) Chas. S. Herstadt, M. D.  
, 19 (Address) 221 S. B' Way.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER H. Mary Trippel Ref. March 28 1922  
Wendell D. Addison ADDRESS 378 m

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



D 6281P

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 6281P

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 838 N. Lexington ST. 18 WARD)REGISTERED No. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Hibbitts(a) RESIDENCE. No. 838 N. Lexington ST. 18 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married.5a If married, widowed, or divorced HUSBAND of Geo. W. Hibbitts (or) WIFE of6 DATE OF BIRTH (month, day, and year) Oct 10 18667 AGE Years 55 Months 5 Days 12 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)10 NAME OF FATHER Edu. Poche11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)12 MAIDEN NAME OF MOTHER Mary Bulger13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)14 Informant Miss Helen Hibbitts (Address) 838 N. Lexington St.15 MAR 27 1922 ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 192217 I HEREBY CERTIFY, That I attended deceased from Jan 10 1921 to March 23 1922 that I last saw her alive on March 23 1922and that death occurred, on the date stated above, at 12 40 p.m.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis  
Diabetes(duration) 1 yrs. 3 mos. 7 da.CONTRIBUTORY (Secondary) Yacemia

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical(Signed) Edw. V. Coolahan M. D.3/25 1922 Address) 24 N. Fulton Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

New Cathedral3/27/22

20 UNDERTAKER

Henry B. Raymond

ADDRESS

517 N. Schenck

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62812

## CERTIFICATE OF DEATH.

90 D 62812

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2100 Penrose Ave ST.; 20 WARD)

## REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary M. Allwalt(Residence in Baltimore: No. 2100 Penrose Ave St.; 62 yrs., 11 mos., 1 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE,

White

## 5-SINGLE,

MARRIEDWIDOWED,OR DIVORCED,

(Write the word.)

## 6-DATE OF BIRTH,

Apr. 22, 1859  
(Month) (Day) (Year)

## 7-AGE,

62 yrs., 11 mos., 1 ds.

If LESS than 1 day,

....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

at home9-BIRTHPLACE,  
(State or Country),Balto City

## 10-NAME OF FATHER,

Jacob Murler11-BIRTHPLACE OF FATHER,  
(State or Country),Germany

## 12-MAIDEN NAME OF MOTHER

unknown13-BIRTHPLACE OF MOTHER  
(State or Country),Germany

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. R. Allwalt(Address) 2100 Penrose Ave

## 15-

MAR 27 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

March 23, 1922  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from March 1923, to March 23, 1922, that I saw her alive on March 22, 1922, and that death occurred, on the date stated above, at 8:30 P.M.  
The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis(Duration) 2 yrs., 11 mos., 1 ds.CONTRIBUTORY  
(Secondary)Acute cardiac dilatation(Duration) 1 ds.(Signed) B. J. Rader M. D.3-26, 1922 (Address) 2306 E. E. Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs., 11 mos., 1 ds. In the State 2 yrs., 11 mos., 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

London ParkMar. 27, 1922

## 20-UNDERTAKER

## ADDRESS

Mr. Rader 2503 Edmonson Ave

N. B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62813

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1848 N. Chester ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1848 N. Chester St.; 67 yrs., 1 mos., 1 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE.

White5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)  
Widow

## 6-DATE OF BIRTH

February 25, 1955  
(Month) (Day) (Year)

## 7-AGE.

67 yrs., 1 mos., 1 ds.If LESS than 1 day,  
....hrs. or ....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).Home Keeper  
0009-BIRTHPLACE.  
(State or Country).Maryland

## PARENTS.

## 10-NAME OF FATHER.

Patrick Donnelly11-BIRTHPLACE OF FATHER  
(State or Country).Ireland

## 12-MAIDEN NAME OF MOTHER

Not known13-BIRTHPLACE OF MOTHER  
(State or Country).Ireland

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MAR 27 1922ROBERT R. KRAUTER,

Filed

191

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

March 24, 1922  
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from Mar 20, 1922, to Mar 24, 1922, that I saw h. alive on Mar 24, 1922, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY  
(Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed)

Richard J. Gorman, M. D.  
Mar 24, 1922 (Address) 1514 E. Baltimore St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

## DATE OF BURIAL.

Holy RedeemerMarch 28, 1922

## 20-UNDERTAKER

ADDRESS 1203Henry LutzW. Broadway

N.B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION, CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62814

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 270 N. Exeter ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Rosie Rappazo

(Residence in Baltimore: No. 270 N. Exeter

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE.

White

5-SINGLE, MARRIED, Widowed, OR DIVORCED. (Write the word.) Single

## 6-DATE OF BIRTH.

March 17, 1922  
(Month) (Day) (Year)

## 7-AGE.

9 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Infant

9-BIRTHPLACE.  
(State or Country).

270 N. Exeter St

## 10-NAME OF FATHER.

Joseph Rappazo

11-BIRTHPLACE OF FATHER.  
(State or Country).

Italy

## 12-MAIDEN NAME OF MOTHER.

Josephine D'Agostino

13-BIRTHPLACE OF MOTHER.  
(State or Country).

New York

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Joseph Rappazo

(Address)

270 N. Exeter St

## 15-

ROBERT R. KRAUTER,

MAR 27 1922

Burial Permit Clerk... Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

March 26, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 17 1922, to March 25 1922, that I saw her alive on March 25 1922, and that death occurred, on the date stated above, at 6:30 a. m. The CAUSE OF DEATH\* was as follows:

Congenital mitral regurgitation  
(Duration) yrs. mos. 9 ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. B. M. D.

3-26, 1922 (Address) 2306 Eutaw Pl.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

St Vincent Cemetery

## DATE OF BURIAL.

March 27 1922

## 20-UNDERTAKER

George F. Ruth

## ADDRESS

1735 Taylor Ave.

N. B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.



D 62815

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 D 62815  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 788 W. Saratoga

ST. 4

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Bessie Roy

(Residence in Baltimore: No. 788 W. Saratoga

St.: 4 yrs., 5 mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE. Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, March 15, 1910 (Month) (Day) (Year)

7-AGE, 12 yrs., 1 mos., 1 da. If LESS than 1 day, hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Va

10-NAME OF FATHER, Abraham L. Roy

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Lena Weinfeld

13-BIRTHPLACE OF MOTHER (State or Country), Va

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Abraham L. Roy

(Address), 788 Saratoga st

15-

MAR 27 1922 ROBERT A. KRAUTER, Registrar.

Filed.

Burial Permit

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 24<sup>th</sup>, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 27, 1920, to Sept 19, 1921, that I saw her alive on Sept 19, 1921, and that death occurred, on the date stated above, at 11 P. m. The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(Duration) 2 yrs., 1 mos., 1 da.

CONTRIBUTORY (Secondary)

(Duration) yrs., mos., da.

(Signed) Chas. K. Miller, M. D.

Mar 25, 1922 (Address) 522 W. Lombard st.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs., mos., da. In the State yrs., mos., da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, March 27, 1922

20-UNDERTAKER, A. Jones

ADDRESS, 207 S. Stricker st

N.B.—Every item of information should be carefully supplied. AGE, SEX, and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62816 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3812 Pleasant Place ST. WARD)

## 2. FULL NAME:

(a) RESIDENCE NO. 3812 Pleasant Place ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

26 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

F

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb 28 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAR 27 1922

ROBERT R. KRAUTER, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1922

17

I HEREBY CERTIFY, That I attended deceased from 2-22, 1922 to 3-26, 1922 that I last saw her alive on 2-25, 1922

and that death occurred, on the date stated above, at 1 P.m.

The CAUSE OF DEATH\* was as follows:

Patent Foramen Ovale

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

26 ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 20 Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

3-26-1922 (Address)

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

St Marys Hospital March 27 1922  
Chenoweth & Co Chestnut St

N. B.—WRITE PLAINLY, WITH EXACT STATEMENT OF OCCUPATION, CAUSE OF DEATH, and AGE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62817

## CERTIFICATE OF DEATH.

D 62817

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *3640 Ash* ST. *13* WARD)2. FULL NAME *Thomas M. Falls*(a) RESIDENCE NO. *3640 Ash*

(Usual place of abode)

ST. *13*

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. *9* mos. *5* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*5a If married, widowed, or divorced, HUSBAND of (or) WIFE of *✓*6 DATE OF BIRTH (month, day, and year) *June 2 1921*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *9* *5*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *✓*(b) General nature of industry, business, or establishment in which employed (or employer) *✓*(c) Name of employer *✓*9 BIRTHPLACE (city or town) *Ind*  
(State or country)10 NAME OF FATHER *Harvey Falls*11 BIRTHPLACE OF FATHER (city or town) *Ind*  
(State or country)12 MAIDEN NAME OF MOTHER *Maggie Ruby*13 BIRTHPLACE OF MOTHER (city or town) *Ind*  
(State or country)14 Informant *Maggie Falls*  
(Address) *3640 Ash St*15 *MAR 27 1922* ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 26 1922*17 I HEREBY CERTIFY, That I attended deceased from *Mar 25 1922* to *Mar 26 1922* that I last saw him alive on *Mar 26 1922* and that death occurred, on the date stated above, at *110 A.M.*  
The CAUSE OF DEATH\* was as follows:*Broncho-Pneumonia*(duration) yrs. mos. / *2* ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Howard E. Hoff*, M. D.*3/27 1922* (Address) *2020 K. Charles*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*St Marys Hospital* *March 28 1922*

20 UNDERTAKER ADDRESS

*Chenoweth Son* *Chestnut St*

N. B.—WRITE PLAINLY, WITH CARE. Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 62818

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62818

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *3449 Ash*)ST., *13* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

*Eva Ashby*

## (a) RESIDENCE NO.

*3449 Ash*

ST., ... WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *3* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F.* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *H.F. Ashby*6 DATE OF BIRTH (month, day, and year) *Apr 25 1905*7 AGE *16* Years *10* Months *28* Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *md* (State or country)10 NAME OF FATHER *Charles M. Talbott*11 BIRTHPLACE OF FATHER (city or town) *md* (State or country)12 MAIDEN NAME OF MOTHER *Lona Walker*13 BIRTHPLACE OF MOTHER (city or town) *md* (State or country)14 Informant *Lona Talbott* (Address) *3449 Ash*15 *MAR 27 1922* REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 25 1922*17 I HEREBY CERTIFY, That I attended deceased from *3/20* 19*22*, to *3/25* 19*22*, that I last saw her alive on *3/25* 19*22*, and that death occurred, on the date stated above, at *10 a.m.* The CAUSE OF DEATH\* was as follows:*Broncho - Pneumonia*(duration) yrs. mos. *8* ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *G. W. ...* M. D.3/26 1922 (Address) *2020 N. Charles*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Brownsville md March 28 1922*

20 UNDERTAKER

ADDRESS

*Cohenowich & Son Chestnut St*





## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62820

## CERTIFICATE OF DEATH.

D 62820

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *18* WARD)

## 2-FULL NAME

(a) RESIDENCE. No. *912 Hallms* ST. WARD.

(Usual place of abode)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred *60* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of *Michael Burke*6 DATE OF BIRTH (month, day, and year) *7 1862*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *60*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*(b) General nature of industry, business, or establishment in which employed (or employer) *ooo*

(c) Name of employer

9 BIRTHPLACE (city or town) *md* (State or country)10 NAME OF FATHER *Patrick Hayes*11 BIRTHPLACE OF FATHER (city or town) *Ireland* (State or country)12 MAIDEN NAME OF MOTHER *Mary Lyons*13 BIRTHPLACE OF MOTHER (city or town) *Ireland* (State or country)14 Informant *Mercy Hospital Records* (Address)15 *MAR 27 1922* ROBERT R. KRAUTER, Registrar Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 25 22*17 HEREBY CERTIFY, That I attended deceased from *March 21 22* to *March 25 22*that I last saw her alive on *March 25 22* and that death occurred, on the date stated above, at *6:25 a. m.*

The CAUSE OF DEATH\* was as follows: -

*Cystitis*

CONTRIBUTORY (Secondary)

18 Where was disease contracted *Home* if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical signs*(Signed) *John J. Brown* M. D., 19 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*St. Peter's Cem* *Mar 28 1922*20 UNDERTAKER *John J. Brown* ADDRESS *901 Hollaugh*

N. B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 62821

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62821

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes' Hospital* WARD)

## 2-FULL NAME

*Mrs. Mary Kilian*(a) RESIDENCE NO. *202 S. Bruce St.*

(Usual place of abode)

Length of residence in city or town where death occurred *10* yrs. — mos. — ds.

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? *20* yrs. — mos. — ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White**Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Carl Kilian*6 DATE OF BIRTH (month, day, and year) *Jan 4 - 1887*

7 AGE

Years

Months

Days

If LESS than 1 day, .... hrs. or .... min.

*35**2**22*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

*037*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Hungary*

10 NAME OF FATHER

*John Kilian*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Hungary*

12 MAIDEN NAME OF MOTHER

*Mary Baker*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Hungary*

14

Informant (Address)

*Mrs. E. L. Kilian 202 S. Bruce St.*

15

ROBERT R. KRAUTER, Registrar

MAR 27 1922

Burial Permit

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-26-22*17 I HEREBY CERTIFY, That I attended deceased from *3-14*, 19*22*, to *3-26*, 19*22*.that I last saw *her* alive on *3-24*, 19*22*and that death occurred, on the date stated above, at *1:50 a. m.*

The CAUSE OF DEATH\* was as follows:

*Thrombosis of pelvic veins -*

(duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of *3-17-22*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *W. L. Caldwell*, M. D.19 (Address) *St. Agnes' Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*London Park Cemetery* *Nov 28 1922*

20 UNDERTAKER

ADDRESS

*F. B. Neupert 2236 Freshwater*

N. B.—WRITE PLAINLY, WITH UNFOLDING FOR PHYSICIANS. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS

BY PHYSICIAN.

Operation for tuboovarian  
cyst probably gonococcus  
infection.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

62822

## CERTIFICATE OF DEATH.

89 D 62822

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No

929 Madison St.

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Anne B. Johnson

## (a) RESIDENCE. No.

929 Madison St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Unknown

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

About 69 years

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Dressmaker, old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Staunton, Va.

## 10 NAME OF FATHER

Jas. W. Johnson

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va.

## 12 MAIDEN NAME OF MOTHER

Margaret Jordan

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va.

## 14

Informant (Address)

May V. Johnson 929 Madison

## 15

MAR 27 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26th 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

January 1914 to March 26th 1922. that I last saw her alive on March 26th 5:30 PM 1922.

and that death occurred, on the date stated above, at 6:10 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Heart Disease with Nephritic Complications

## CONTRIBUTORY (Secondary)

(duration) 20 yrs. - mos. ds.

Angina Pectoris

(duration) 45 min. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed)

William H. Smith, M. D.

19

(Address) J. W. Cr. Casualty

\*State the Disease Causing Death, or in deaths from Violent Cause, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Woodstock Va

## DATE OF BURIAL

3/28 1922

## 20 UNDERTAKER

George J. Ruth

## ADDRESS

1735 Harbor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62823

D 62823

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 Talbott Road ST. 15 WARD)

## 2-FULL NAME

Sallie Buxton Shaffer

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

20 Talbott Road ST. 15 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female white

## 4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

James F. Shaffer

## 6 DATE OF BIRTH (month, day, and year)

July 22, 1853

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

6912

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

## 10 NAME OF FATHER

Thomas Skinner

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa.

## 12 MAIDEN NAME OF MOTHER

Sarah Germaine

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa.

## 14

Informant (Address)

Mrs Geo. A. Orth  
20 Talbott Road

## 15

Filed

MAR 23 1922

ROBERT A. KRAUTER, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24, 1922

17 I HEREBY CERTIFY, That I attended deceased from

March 1, 1922 to March 24, 1922that I last saw her alive on March 24, 1922and that death occurred, on the date stated above, at 6:40 P. m.

The CAUSE OF DEATH\* was as follows:

Broncho-pneumoniaCONTRIBUTORY (Secondary) Parenchymatous Nephritis (duration) yrs. mos. 24 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date ofWas there an autopsy? NOWhat test confirmed diagnosis? Physical(Signed) W. S. Viblett, M. D.(Address) 2220 Garrison av

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Lorraine CemeteryMarch 27, 1922

20 UNDERTAKER

John O. Mitchell 1201 N. FayetteFILE 0034

N. B.—WRITE PLAINLY, WITH EXACTNESS. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62824

## CERTIFICATE OF DEATH.

179

D 62824

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *829 Aisquith*)ST. *10* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

*Walter H Stewart*(a) RESIDENCE NO. *829 Aisquith*

ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *78* yrs. *2* mos. *26* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced, HUSBAND of *Isabella Stewart*6 DATE OF BIRTH (month, day, and year) *December 29<sup>th</sup> 1843*7 AGE Years *78* Months *2* Days *26* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *MD*10 NAME OF FATHER *Joseph J Stewart*11 BIRTHPLACE OF FATHER (city or town) *Wilmington* (State or country) *Del*12 MAIDEN NAME OF MOTHER *Eliza Burgoon*13 BIRTHPLACE OF MOTHER (city or town) *Balt Co* (State or country) *MD*14 Informant *Mrs Isabella Stewart* (Address) *829 Aisquith st*15 *MAR 27 1922* *ROBERT R. KRAUTER* Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 25<sup>th</sup> 1922*17 I HEREBY CERTIFY, That I attended deceased from *Mar 15*, 19 *22*, to *Mar 25*, 19 *22*, that I last saw him alive on *Mar 25*, 19 *22*, and that death occurred, on the date stated above, at *11:15 a. m.*

The CAUSE OF DEATH\* was as follows:

*Tubercle of Pott's Endosteitis*CONTRIBUTORY (Secondary) *Uremia* (duration) *5* yrs. mos. ds. *2* ds.

18 Where was disease contracted if not at place of death? \_\_\_\_\_

Did an operation precede death? *no* Date of \_\_\_\_\_Was there an autopsy? *no*What test confirmed diagnosis? *Physical* (Signature) *Walter H Stewart* M. D. (Address) *1108 N. Caroline*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Greenmount Cemetery*

DATE OF BURIAL

*Mar 28<sup>th</sup> 1922*

20 UNDERTAKER

ADDRESS

*George Schilling & Sons**1126 E Monument st*

N. B.—WRITE PLAINLY, and be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCASION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Information should be carefully supplied. All statements should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Rec.—6-9-19—H. P. Co.—1000 Bks.

D 62825

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62825

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1428 Patapsco*)

ST. *23* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *William Henry Buckman*

(a) RESIDENCE. No. *1428 Patapsco*

ST. WARD.

(Usual place of abode)

(If nonresident give city and town and State)

Length of residence in city or town where death occurred *57* yrs. *7* mos. *26* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*white*

5 Single, Married, Widowed, or Divorced (write the word)

*married*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

*Anna M. Buckman*

6 DATE OF BIRTH (month, day, and year) *July 28-1867*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*54*

*7*

*26*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Police Officer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Globe Ship Building Co*

9 BIRTHPLACE (city or town) (State or country)

*Maryland*

10 NAME OF FATHER

*Buckman*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Maryland*

12 MAIDEN NAME OF MOTHER

*Emily Malloy*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Scotland*

14

Informant

(Address)

*Anna M. Buckman*

*1428 Patapsco St*

15

*MAR 27 1922*

ROBERT R. KRAUTER,

Registrar

Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 24 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*March 15, 1922, to March 24, 1922.*

that I last saw him alive on *March 24, 1922.*

and that death occurred, on the date stated above, at *9 P.* m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma Stomach*

(duration) *1* yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Exhaustion*

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? ☒

Did an operation precede death? *no* Date of ☒

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *J. P. Buckman*, M. D.

*3/25, 1922* (Address) *301 E Cross St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Louisa Park Cemetery*

*Mar 28 1922*

20 UNDERTAKER

ADDRESS

*F. J. France & Son*

*703 Hanover*



D 62826

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

38/D 62826

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 17 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Childs(a) RESIDENCE. NO. 136 Greenwillow St

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---6 DATE OF BIRTH (month, day, and year) 18797 AGE Years Months Days If LESS than 1 day, hrs. or min. 42 -- -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

South Carolina10 NAME OF FATHER Weed Childs

11 BIRTHPLACE OF FATHER (city or town)

(State or country) South Carolina12 MAIDEN NAME OF MOTHER Susan Wildman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) South Carolina

14

Informant Hospital Records  
(Address) Municipal Hospital

15

MAR 27 1922 ROBERT R. KRAUTER,  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1922

17

I HEREBY CERTIFY, That I attended deceased from January 23, 1922, to March 22, 1922.

that I last saw him alive on March 21, 1922.

and that death occurred, on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH\* was as follows:

Syphilitic aortic insufficiency(duration) 3 yrs. mos. ds.CONTRIBUTORY Myocardial infarct.

(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted  
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clayton M. Neill M. D.3/23/22 Address) Municipal Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

HOPKINS HOSPITAL

19

20 UNDERTAKER

ADDRESS

Commissioner HealthMAR 27 1922

N. B.—WRITE FULL NAME OF DECEASED, AGE, SEX, COLOR, and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

D 62827

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

## 2-FULL NAME

(a) RESIDENCE, NO.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos.

ds. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Wht

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan. 6<sup>th</sup> 1848

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

73

2

19

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

013

(c) Name of employer

Butcher

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

H. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ger

12 MAIDEN NAME OF MOTHER

H. Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ger

14

Informant (Address)

H. Miller

2006 Ridgwood

15

MAR 27 1922

ROBERT R. KRAUTER

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25 1922

17 I HEREBY CERTIFY, That I attended deceased from

Mar. 21<sup>st</sup> 1922 to Mar 25<sup>th</sup> 1922that I last saw him alive on Mar 24<sup>th</sup> 1922

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Hemorrhage of brain (apoplexy)

(duration) yrs. mos. 4 da

CONTRIBUTORY (Secondary) Paralysis

(duration) yrs. mos. 3 da

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Visual

(Signed) E. Smith, M. D.

25 15 Address 1600 W North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Cemetery Mar 28 1922

20 UNDERTAKER

J. L. Syfer 1600 W North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62828

## CERTIFICATE OF DEATH

113 D 62828

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1411 Harford Ave.* ST.: *9* WARD)

## 2-FULL NAME

*Edwin S. Badinger*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE

No. *1411 Harford Ave.* ST.: \_\_\_\_\_ WARD: \_\_\_\_\_

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Child*

## 5a If married, widowed, or divorced

BUSBAND of  
(or) WIFE of*Child*

## 6 DATE OF BIRTH (month, day, and year)

*Mar 16 1921*

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*4**9*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Balto, Md.*

## 10 NAME OF FATHER

*Philip A. Badinger*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Balto, Md.*

## 12 MAIDEN NAME OF MOTHER

*Bridget H. Harin*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Balto, Md.*

## 14

Informant

(Address)

*Bridget Badinger  
1411 Harford Ave.*

## 15

*MAR 27 1922*ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*March 25 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*March 23 1922 to March 25 1922*that I last saw him alive on *March 25th 1922*and that death occurred, on the date stated above, at *2:30 PM*

The CAUSE OF DEATH\* was as follows:

*Illis Colitis*

(duration)

yrs.

mos.

ds. *10*CONTRIBUTORY  
(Secondary)*Intestinal Paresis*

(duration)

yrs.

mos.

ds. *2*

## 18 Where was disease contracted

if not at place of death?

*Unknown*

## Did an operation precede death?

*no*

Date of

## Was there an autopsy?

*no*

## What test confirmed diagnosis?

*Chemical findings*

(Signed)

*Walter Fuller*

M. D.

, 19

(Address)

*1506 N. Broadway*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*London Park Cemetery**Mar 27 1922*

## 20 UNDERTAKER

## ADDRESS

*Edwin W. Conkle**224 E. Eager*

mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.





## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH  
D 62830

CITY OF BALTIMORE: No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

17, 19, to March 24, 1922

that I last saw him alive on March 24, 1922

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH\* was as follows:

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Z. Burke, M. D.

19 (Address) 3042 Hudson St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

1. B—WRITE FATHER'S NAME, MOTHER'S NAME, AND ADDRESS OF DECEASED IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

2. AGE should be carefully supplied. AGE should be stated EXACTLY.

3. CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

MAR 27 1922

ROBERT A. KRAUTER

19 PLACE OF BURIAL CREMATION OR RE-MOVAL: Oak Lawn Cemetery

DATE OF BURIAL: MAR 28 1922

20 UNDERTAKER: Robert J. Turner

ADDRESS: 1412 E. 1st St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62831

## CERTIFICATE OF DEATH.

91-002  
D 62831

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 759 E 30th ST., 9 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

(a) RESIDENCE NO. 759 E 30th ST., 9 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? 60 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Widower5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Nov 22 1832

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.8942

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Cabinet Maker9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant  
(Address)

15

Robert R. Krauter,  
759 E 30th St  
MAR 27 1922ROBERT R. KRAUTER,  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 1, 1919 to Mar 24 1922,  
that I last saw him alive on Mar 23 1922,  
and that death occurred, on the date stated above, at 12 45 m.

The CAUSE OF DEATH\* was as follows:

Senile Arterio Sclerosis  
about (duration) 4 yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

124 1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

London ParkRobert L. Turner IncMar 27 19221442 Broadway

N. B.—WRITE FULL NAME OF DECEASED IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. See instructions on back of certificates.

# Cornelia N Mallon ✓

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62832

## CERTIFICATE OF DEATH.

174 D 62832

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1)

## 2-FULL NAME

(Residence in Baltimore: No. 1512 Halbrook St.

REGISTERED NO. C

WARD) 9

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE,

White

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

## 6-DATE OF BIRTH,

May 18th

1838

(Month)

(Day)

(Year)

## 7-AGE,

84

10

yrs. mos. da.

## If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

037

## 9-BIRTHPLACE, (State or Country).

Newark N. J.

## 10-NAME OF FATHER,

Don't know

## 11-BIRTHPLACE OF FATHER (State or Country).

Newark N. J.

## 12-MAIDEN NAME OF MOTHER

Don't know

## 13-BIRTHPLACE OF MOTHER (State or Country).

Newark N. J.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Robert B. Mallon

(Address)

1502 Halbrook St.

## 15-

MAR 27 1922

ROBERT R. KRAUTER,

Filed

151

Burial Permit: Clerk;

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

mch 26

1922

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

mch 27 1922, to mch 26 1922,

that I saw her alive on mch 26 1922,

and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. da.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed)

S. W. Krauter, M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Lind Ridge

## DATE OF BURIAL,

Mar. 28., 1922

## 20-UNDERTAKER

Holt &amp; Turner Inc

## ADDRESS

1446 N Broadway

Every item of information should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62833

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 601 N. Bond

ST. 7 WARD)

2-FULL NAME Mary C. Braun

(a) RESIDENCE. No. 601 N. Bond  
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? 75 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE White	5 Single, Married, Widowed, or Divorced (write the word) Widow
5a If married, widowed, or divorced <del>HUSBAND</del> (or) WIFE of Late Conrad Braun		
6 DATE OF BIRTH (month, day, and year) Apr 15-43		
7 AGE Years 78	Months 11	Days 10 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work  
House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER Anna Hentzgerling

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant Mrs J. F. C. Stein  
(Address) 601 N. Bond St.

15

MAR 27 1922 ROBERT A. KRAUTER  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25 1922

17 I HEREBY CERTIFY, That I attended deceased from  
March 18<sup>th</sup>, 1922, to March 25<sup>th</sup>, 1922,  
that I last saw her alive on March 24<sup>th</sup>, 1922,  
and that death occurred, on the date stated above, at 5:30 a. m.  
The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Howard C. Selzer, M. D.

19 (Address) 3706 Liberty Highways av

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Baltimore

3/28 1922

## 20 UNDERTAKER

Philip Herwig

ADDRESS 2016  
Orleans



D 62834 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62834

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Hydenham Hospital* St. *26* Ward)

Registered No. C. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *Woodbine Ave near Eastern Ave* St.; yrs. .... mos. .... ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *white* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Single*6-DATE OF BIRTH, *Mar 9*, 18*96* (Month) (Day) (Year)7-AGE, *26* yrs. .... mos. .... ds. If LESS than 1 day, .... hrs. or .... min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Foreman* (b) General nature of industry, business, or establishment in which employed (or employer), *Shell Business*9-BIRTHPLACE, (State or Country), *Balto*10-NAME OF FATHER, *Mr Taylor*11-BIRTHPLACE OF FATHER, (State or Country), *Md*12-MAIDEN NAME OF MOTHER, *Mary*13-BIRTHPLACE OF MOTHER, (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Henry F. Taylor*(Address) *Woodbine Ave near Eastern Ave*

15-ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk, *MAR 27 1922*

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Mar 23*, 19*22* (Month) (Day) (Year)17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Heart* (Duration) .... yrs. .... mos. .... ds.CONTRIBUTORY (Secondary) *Artery* (Duration) .... yrs. .... mos. .... ds.(Signed) *W. H. Smith* M. D. (Coroner.)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, *Oak Lawn* DATE OF BURIAL, *3/27*, 19*22*20-UNDERTAKER, *Philip Herwig* ADDRESS *Orleans St.**No 5507*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62835

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hosp.* ST.; *8* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Russell Watson*(Residence in Baltimore: No. *1618 E. Linnvale St.* St.; yrs. mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*M.*

4-COLOR OR RACE,

*W*5-SINGLE,  
MARRIED, *S.*  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

....., *1921*  
(Month) (Day) (Year)

7-AGE,

yrs. *11* mos. da.If LESS than 1 day,  
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,  
(State or Country),*Balto*

10-NAME OF FATHER,

*William Watson*11-BIRTHPLACE OF FATHER  
(State or Country),*NC*

12-MAIDEN NAME OF MOTHER

*Mabel Kern*13-BIRTHPLACE OF MOTHER  
(State or Country),*Balto*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Mabel Watson*(Address) *1618 E. Linnvale*

15-

Filed

MAR 27 1922

ROBERT R. KRAUTER,

Burlar Permit Registration

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

..... *Mar* ..... *27* ..... *1921*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Mar 21 1921*, to *Mar 27 1921*,that I saw him alive on *Mar 27 1921*,and that death occurred, on the date stated above, at *9 p.m.*

The CAUSE OF DEATH\* was as follows:

*Empyema*

..... (Duration) ..... yrs. .... mos. .... da.

CONTRIBUTORY *Alcoholism*  
(Secondary)

..... (Duration) ..... yrs. .... mos. .... da.

(Signed) *R. C. Marino* M. D.*Mar 27, 1921* (Address) *St. Joseph's Hosp.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. .... mos. .... da. In the State ..... yrs. .... mos. .... da.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Baltimore Am**Mar 30 1921*

20-UNDERTAKER

ADDRESS

*John Henry & Co**2008 Orleans*

N. B. Every item on this certificate should be filled in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62836

## CERTIFICATE OF DEATH.

57 D 62836

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2937 Eastern Ave ST., 76 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Warren Culberson

## (a) RESIDENCE NO.

2937 Eastern Ave ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs.

mos.

ds.

Now long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofOlivia Culberson

## 6 DATE OF BIRTH (month, day, and year)

Feb 20, 1864

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.5817

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Copper Roller

(b) General nature of industry, business, or establishment in which employed (or employer)

086

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Balto

## 10 NAME OF FATHER

Don't know11 BIRTHPLACE OF FATHER (city or town)  
(State or country)MD

## 12 MAIDEN NAME OF MOTHER

Don't know13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)MD

## 14

Informant  
(Address)Geo Culberson  
2937 Eastern Ave

## 15

MAR 27 1922ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

1 Mar, 1922, to 26 Mar, 1922.that I last saw him alive on 26 Mar, 1922.and that death occurred, on the date stated above, at 1:40 a.m.

The CAUSE OF DEATH\* was as follows:

Diabetic Jaundice  
Septicemia

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)Diabetes Mellitus  
at least 6 yrs. mos. ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? yes Date of 27 Mar 22Was there an autopsy? noWhat test confirmed diagnosis? urinalysis

(Signed)

W. H. Mueller, M. D.

, 19

(Address)

3018 Ellwood

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Parkwood Cemetery

## DATE OF BURIAL

March 27 1922

## 20 UNDERTAKER

John Hersey & Co

## ADDRESS

2007 Orleans

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62837

## CERTIFICATE OF DEATH.

44  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 90232nd ST., 26 WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ST.,

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced, (write the word)

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Annie Barthol

6 DATE OF BIRTH (month, day, and year)

Nov 18, 1863

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

58

4

7

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Labourer

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Balto Md

10 NAME OF FATHER

Nicholas Lemick

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Germany

14

Informant  
(Address)Annie Lemick  
90232nd

15

MAR 27 1922

ROBERT A. KRAUSE

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 25 1922

17 I HEREBY CERTIFY, That I attended deceased from  
Dec 26, 1921, to Mar 25, 1922

that I last saw him live on Mar 24, 1922

and that death occurred, on the date stated above, at 4:30 am

The CAUSE OF DEATH\* was as follows:

Gastric Carcinoma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed)

Dr. Heller

M. D.

3/26/22 Address) 1937 Gough St

\*State the Disease Causing Death, or in death from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Oak Lawn

DATE OF BURIAL

Mar 28 1922

20 UNDERTAKER

John Henry &amp; Co

ADDRESS

2001 Olsen

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62838

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 Moreland Ave. ST., 15 WARD)

## 2-FULL NAME

Sarah Rosa Fisher(a) RESIDENCE NO. 1614 Moreland Ave. ST., 15 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 9 mos. 9 ds. How long in U. S., if of foreign birth? 9 yrs. 9 mos. 9 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced HUSBAND or (or) WIFE William Fisher6 DATE OF BIRTH (month, day, and year) Mar 23 19227 AGE Years 68 Months — Days — If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia10 NAME OF FATHER Morris Fuchs11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia12 MAIDEN NAME OF MOTHER Shana13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14

Informant (Address) Jack Lewis 1439 E. Baltimore St.

15

0001 2844

ROBERT R. KRAUTER, Registrar

Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1922

17

I HEREBY CERTIFY, That I attended deceased from Mar 23, 1922, to Mar 26, 1922,that I last saw him alive on Mar 26, 1922, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia(duration) yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Larry Boyd, M. D.Address 602 Columbia

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Kehren Int. Cemetery3/27 1922

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E. Baltimore St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62839

## CERTIFICATE OF DEATH.

161-001  
D 62839  
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401-11-Central ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Applebaum

(Residence in Baltimore: No. 1401-11-Central av St.; X yrs., X mos. 8 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.) X

6-DATE OF BIRTH,

March 18, 1922  
(Month) (Day) (Year)

7-AGE,

X yrs., X mos., 8 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wolf Appelbaum

(Address) 1401 St. Central av.

15-

Filed MAR 27 1922 ROBERT H. ZERLIN Registrar.

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 26, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from MAR 18 1922 191, to MAR 26 1922 191,

that I saw h. (M) alive on MAR 26 1922 191, and that death occurred, on the date stated above, at 10:30 m.

The CAUSE OF DEATH\* was as follows:

Skewers of some metal  
spines driven into the chest  
was fatal.CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

MAR 27 1922 (Address) 1401 St. Central av.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Reburied in Friendsbury, Md. 3/27/22, 1912

20-UNDERTAKER ADDRESS

Jack Lewis 1439 51st St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 62840

62840

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2101 E. Balt. ST., 1 WARD)

2-FULL NAME Rochel Ohrenstein

(a) RESIDENCE NO. 2101 E. Balt. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female white widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAR 27 1922

ROBERT R. KRAUTER,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/26 1922

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1922, to March 25, 1922,

that I last saw her alive on March 25, 1922,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH\* was as follows:

Asthma Bronchitis

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

3/27, 1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62841

## CERTIFICATE OF DEATH.

31 D 62841

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 1/2 E. Clement St. ST. 24 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. McGee Jr.

(a) RESIDENCE No. 132 1/2 E. Clement  
(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1896

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
26 1 3

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer9 BIRTHPLACE (city or town) Balto. Md.  
(State or country)

10 NAME OF FATHER Wm. J. McGee

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.  
(State or country)

12 MAIDEN NAME OF MOTHER Mamie Morgan

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.  
(State or country)14 Informant Mrs. W. Bergesen  
(Address) 132 1/2 E. Clement St.15 Registrar  
MAR 27 1922 ROBERT R. KRAUTER

Burial Permit

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 25th, 1922

17 I HEREBY CERTIFY, That I attended deceased from 3/13 to 3/25, 1922, that I last saw him alive on March 24, 1922, and that death occurred, on the date stated above, at 1:30 p. m. The CAUSE OF DEATH\* was as follows:  
Cerebral hemorrhageCONTRIBUTORY (Secondary) Pulmonary tuberculosis  
(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? hmc.

(Signed) C. M. White M. D.  
4/26, 1922 (Address) 1277 Madison St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cedar Hill Cemetery

DATE OF BURIAL

Mar. 27 1922

20 UNDERTAKER

E. I. Fanning &amp; Son-1038 E. Lafayette

N. B. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.



**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person. Irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Phy. could give no  
cause for cerebral hemorrhage  
Not traumatic. Perhaps  
deceased realized he was dying  
& shock could have produced  
hemorrhage.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62842

## CERTIFICATE OF DEATH.

D 62842

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3422 E. Lombard ST., 26 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. 3422 E. Lombard ST., 26 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of —6 DATE OF BIRTH (month, day, and year) Jun 23 19227 AGE Years Months Days If LESS than 1 day, hrs. or min. 2 2

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None(b) General nature of industry, business, or establishment in which employed (or employer) —(c) Name of employer —9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)10 NAME OF FATHER Stanley D. Hughes11 BIRTHPLACE OF FATHER (city or town) Baltimore Co. Md. (State or country)12 MAIDEN NAME OF MOTHER Minnie Shorley13 BIRTHPLACE OF MOTHER (city or town) Baltimore Co. Md. (State or country)14 Informant Stanley D. Hughes (Address) 3422 E. Lombard St.15 MAR 27 1922 ROBERT R. KRAUTER, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 192217 I HEREBY CERTIFY, That I attended deceased from March 23, 1922, to March 25, 1922, that I last saw him alive on March 25, 1922, and that death occurred, on the date stated above, at 10.45 a. m.

The CAUSE OF DEATH\* was as follows:

Broncho pneumonia(duration) yrs. mos. 5 ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Geo. J. Lockwood M. D.19 (Address) 806 S. 3rd St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Oak Lawn Cem.

DATE OF BURIAL

3/27/22

20 UNDERTAKER

Lilly Ed Zeiler

ADDRESS

403 S. Wolfe

N. B.—Wherever the word "AGE" should be supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior*

✓

### CERTIFICATE OF DEATH.

D 62843

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 113 N. Webster ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred      yrs.      mos.      ds.      How long in U. S., if of foreign birth?      yrs.      mos.      ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 19 22

17 I HEREBY CERTIFY, That I attended deceased from  
Mar 24 1922 to Mar 26 1922

that I last saw her alive on April 26 1922.

and that death occurred, on the date stated above, at 100 St.

The CAUSE OF DEATH\* was as follows:

Member

(duration) 2 yrs. 1 mos. 3 da.

CONTRIBUTORY (Secondary) *Bronchitis*

(duration) ..... yrs. ✓ ..... mos. ✓ ..... ds.

18 Where was disease contracted *Place death*  
if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Thyroid Function Tests

(Signed) John S. Crawford M.D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

[illegible]

20 UNDERTAKER	ADDRESS
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$\mu^+ / \mu^-$   $\approx 11$  Superficially  $\mu^+ / \mu^-$

\_\_\_\_\_



D 62844 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 D 62844

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4714 Liberty Heights Ave. 27 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Marie W. Klingebiel

## (a) RESIDENCE. NO.

4714 Liberty Heights Ave. ST.

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year) Apr 10. 1889

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

32

11

14

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Datapac Iron Works

## 9 BIRTHPLACE (city or town) (State or country)

Balto. Md

## 10 NAME OF FATHER

Henry Klingebiel

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Lena Hoffman

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

## 14

Informant (Address)

Henry Klingebiel 4714 Liberty Heights Ave.

## 15

MAR 27 1922

ROBERT A. KRAUER

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) Mar 24 1922

## 17

I HEREBY CERTIFY, That I attended deceased from Feb 1, 1922, to Mar 24, 1922, that I last saw her alive on Mar 24, 1922, and that death occurred, on the date stated above, at 11:55 P. M.

The CAUSE OF DEATH\* was as follows:

Laryngeal + Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

## CONTRIBUTORY (Secondary)

Exhaustion

(duration) yrs. 1 mos. ds.

## 18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) Herbert C. Blah, M. D.

19 (Address) 1014 W La Fayette

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Western Cem.

## DATE OF BURIAL

Mar 28 1922

## 20 UNDERTAKER

Mr + Mrs J. W. Trefel + Son 801 W. Fayette

N. B.—WRITE PLAINLY, WITH CAPITALS, IN INK. AGE should be stated EXACTLY. PHYSICIAN should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62845

## CERTIFICATE OF DEATH.

21 D 62845

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Lake Drive apt* ST. *13* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Herbert Chessler*(Residence in Baltimore: No. *Lake Drive apt* St. ; yrs. ; mos. *19* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *m.* 4-COLOR OR RACE *w.* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)6-DATE OF BIRTH, *march 7, 1922*  
(Month) (Day) (Year)7-AGE, *19* yrs. ; mos. ; ds. If LESS than 1 day, ....hrs. or....min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *City*10-NAME OF FATHER, *Harry Chessler*11-BIRTHPLACE OF FATHER (State or Country), *md.*12-MAIDEN NAME OF MOTHER *Bessie Weir*13-BIRTHPLACE OF MOTHER (State or Country), *md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harry Chessler*(Address) *Lake Drive apt 8*

15-

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *march 27, 1922*  
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *3/26* 1922, to *march 26* 1922, that I saw him alive on *3/26* 1922, and that death occurred, on the date stated above, at *m.* The CAUSE OF DEATH\* was as follows:  
*Erysipelas*  
(Duration).....yrs.....mos.....ds.  
CONTRIBUTORY.....  
(Secondary).....  
(Duration).....yrs.....mos.....ds.  
(Signed) *U. G. Friedman* M. D.  
*3/27*, 1922 (Address) *918 E. Fayette*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Hebrew Friendship* DATE OF BURIAL, *March 27, 1922*20-UNDERTAKER *Jol. Levins* ADDRESS *id 7 E Baltimore*

MAR 27 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Enter statement of cause of death on back of certificate. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62846

## CERTIFICATE OF DEATH.

D 62846

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2417 W. North Ave ST., 5 WARD)2. FULL NAME Fannie Brown(a) RESIDENCE NO. 2417 W. North Ave ST., 5 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. 3 mos. 0 ds.(If non-resident, give city or town and State)  
How long in U. S., if of foreign birth? 38 yrs. 3 mos. 0 ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Fannie6 DATE OF BIRTH (month, day, and year) March 26 19227 AGE Years 68 Months — Days — If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland10 NAME OF FATHER Jacob Levy11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland12 MAIDEN NAME OF MOTHER Ida Smolinski13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia14 Informant Fannie Brown  
(Address) 2417 W. North Ave15 File MAR 27 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 26 192217 I HEREBY CERTIFY, That I attended deceased for  
last 30 or more years, 19 —  
that I last saw her alive on March 26 1922,  
and that death occurred, on the date stated above, at 11:00 P. m.18 CAUSE OF DEATH\* was as follows:  
Pulmonary tuberculosisCONTRIBUTORY  
(Secondary)(duration) Several years ds.18 Where was disease contracted  
if not at place of death? Do not knowDid an operation precede death? No Date of XWas there an autopsy? NoWhat test confirmed diagnosis? Findings of tuber. bacilli, in sputum by B. H. H. C. H. Hoffman, M. D.  
(Signed) 3/27/22Address 3402 W. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Hebrew Southern Ave

20 UNDERTAKER

Map Simonson

DATE OF BURIAL

3/27 1922ADDRESS 1127E. Dalton

N. B.—WRITE FULL NAME, ADDRESS, AND AGE should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. Exact statement of DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62847

## CERTIFICATE OF DEATH.

D 62847

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 N. Bradford ST.: 8 WARD)

## 2-FULL NAME

(a) RESIDENCE. No. 1707 N. Bradford ST., 8 WARD.(Usual place of abode)  
Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? 15 yrs. — mos. — ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Sept 15 18977 AGE Years 24 Months 24 Days 6 If LESS than 1 day, — hrs. — min. 10

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sheet-fitter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer md Ship-yard9 BIRTHPLACE (city or town) Austria  
(State or country)10 NAME OF FATHER August Rock11 BIRTHPLACE OF FATHER (city or town) Moravia Austria  
(State or country)12 MAIDEN NAME OF MOTHER Catherine Krabica13 BIRTHPLACE OF MOTHER (city or town) Moravia Austria  
(State or country)14 Informant August Rock  
(Address) 1707 N. Bradford St.15 **MAR 27 1922**ROBERT H. KRAUTER  
Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25 192217 I HEREBY CERTIFY, That I attended deceased from March 17, 1922, to March 25, 1922, that I last saw him alive on March 25, 1922, and that death occurred, on the date stated above, at 7:55 P m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis(duration) 5 yrs. — mos. — ds.CONTRIBUTORY  
(Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? 2141 E. Chase StDid an operation precede death? No Date ofWas there an autopsy? noneWhat test confirmed diagnosis? none(Signed) D. P. Herzog, M.D. M. D.(Address) 1305 N. Patterson St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy RedeemerMar 28 1922

20 UNDERTAKER

ADDRESS

Frank Wachsman1902  
Ashland

Information should be carefully supplied. Exact statement of OCCURRENCE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62848

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. WARD)

## 2-FULL NAME

Dean Louis Vallery

## (a) RESIDENCE NO.

719 Market St.

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Wilmington, N.C.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of

or WIFE of

Mrs. Katharine E. Vallery

## 6 DATE OF BIRTH (month, day, and year)

May 16, 1859

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

629

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Wholesale Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

034

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

North Carolina

## 10 NAME OF FATHER

Frank Vallery

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Anna E. Phland

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

## 14

Informant (Address)

JOHNS HOPKINS HOSPITAL Records

## 15

MAR 27 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 27, 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan. 22nd, 1922, to March 27, 1922.That I last saw him alive on March 27, 1922and that death occurred, on the date stated above, at 7 A. M.

The CAUSE OF DEATH\* was as follows:

BACTERIAL ENDOCARDITIS (STREP. VIRIDANS)

## CONTRIBUTORY (Secondary)

(duration) — yrs. 6 mos. — ds.

(duration) — yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? BLOOD CULTURES

(Signed)

John L. Dorsey, M. D.

19

(Address)

J. H. H.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Wilmington N. C.

## DATE OF BURIAL

March 27, 1922

## ADDRESS

Georgetown College

## 20 UNDERTAKER

Henry Jenkins & Son Co

N. B.—WRITE EXACT STATEMENT OF OCCUPATION, AGE, SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE CAREFULLY SUPPLIED. CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

D 62849

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

March 24, 1922, to March 26, 1922,

that I last saw him alive on March 25, 1922,

and that death occurred, on the date stated above, at 4 A. M.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage (paralysis -)

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

CONTRIBUTORY (Secondary)

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Paralysis (Hemiplegia)

(Signed) John D. King, M. D.

, 1922 (Address) 1425 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

MAR 27 1922

Information should be carefully supplied. No fee should be charged for this certificate. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

E  
F  
A  
S  
K  
A  
D

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62850

D 62850

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAR 7 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

17

I HEREBY CERTIFY, That I attended deceased from

March 17, 1922, to March 25, 1922

that I last saw him alive on March 25, 1922

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH\* was as follows:

Pneumonia

acute (double)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

At place of death

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Physical examination

(Signed) John J. Hoising, M. D.

Address)

1425 Euton Place

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St John's Cem. Kingville Rd 3/28 1922

20 UNDERTAKER

ADDRESS

Charles J. Coe &amp; Son 118 W. Mt Royal Ave

Information should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 62851

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

101-001 D 62851  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST.; *12* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *2027 N. Charles St.* St. *Unknown* yrs., mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*male*

## 4-COLOR OR RACE.

*white*

## 5-SINGLE

*Single*  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word.)

## 6-DATE OF BIRTH.

*Sept. 1, 1864*  
(Month) (Day) (Year)

## 7-AGE.

*57* yrs. *6* mos. *9* da.

If LESS than 1 day,

...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Retired*  
*Brown Tax Co.*

## 9-BIRTHPLACE.

(State or Country),

*Balto. Co. Md.*

## PARENTS.

## 10-NAME OF FATHER.

*Alfred Gent*

## 11-BIRTHPLACE OF FATHER

(State or Country),

*Balto. Co. Md.*

## 12-MAIDEN NAME OF MOTHER

*Mary E. Holmes.*

## 13-BIRTHPLACE OF MOTHER

(State or Country),

*Balto. Co. Md.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss E. Holmes*(Address) *2027 N. Charles St.*

## 15-

MAR 27 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

*March 26, 1922*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *March 23, 1922*, to *March 26, 1922*, that I saw him alive on *March 26, 1922*, and that death occurred, on the date stated above, at *7:30 p. m.*

The CAUSE OF DEATH\* was as follows:

*Myocardial Insufficiency*(Duration) yrs. mos. da.  
CONTRIBUTORY (Secondary) *Solar pneumonia*(Signed) *Herman Dorf* M. D.  
*March 26, 1922* (Address) *St. Joseph's Hosp.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Shenwood Church Md.**March 27, 1922*

## 20-UNDERTAKER

## ADDRESS

*George J. Rath**1735 Hayford Ave*

N. B.—Every item of information should be in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62852

D 62852

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2429 W. Lantvale ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Shullenberg

(a) RESIDENCE. NO. 2429 W. Lantvale ST. WARD. (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 6 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) Margaret S. Shullenberg

6 DATE OF BIRTH (month, day, and year) Sept 11 1848

7 AGE 73 Years 6 Months 14 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Stone Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

186

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

10 NAME OF FATHER John H. Shullenberg

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Margaret Shaul

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Margaret S. Shullenberg (Address) 2429 W. Lantvale St

15 Filled MAR 27 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

MAR 25 1922

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from Mar. 23 1922, to Mar 25 1922

that I last saw him alive on Mar 25 1922, and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage (Left side of face &amp; side of body paralyzed)

CONTRIBUTORY (Secondary) Arterio-sclerosis (duration) 3 yrs. 3 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wesley Cole M. D.

326 1922 (Address) 220 Harrison

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore

MAR 28 1922

20 UNDERTAKER

Geo W Little Edmondson

Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 62853

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1305 Hollins ST., 19 WARD)

## 2. FULL NAME

John Edward Swift

## (a) RESIDENCE NO.

1305 Hollins

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Winifred M. Swift

## 6 DATE OF BIRTH (month, day, and year)

May 10, 1876

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45

7

16

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Policeman

(b) General nature of industry, business, or establishment in which employed (or employer)

City Police Dept

(c) Name of employer

Baltimore City

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

## 10 NAME OF FATHER

Edward Swift

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

## 12 MAIDEN NAME OF MOTHER

Louise Scheib

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

## 14

Informant (Address)

Winifred M. Swift 1305 Hollins St

## 15

MAR 27 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1922

17

I HEREBY CERTIFY, That I attended deceased from

Mar 16 1922 to Mar 26 1922

that I last saw him alive on Mar 26 1922

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic gastritis

## CONTRIBUTORY (Secondary)

(duration) about 3 yrs. mos. ds.

Pernicious vomiting + starvation

(duration) about 14 yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) H. E. Knapp, M. D.

Mar 27, 1922 (Address) 1002 W. Lanvale

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

## 20 UNDERTAKER

Lorraine

## DATE OF BURIAL

Mar 30, 22

## ADDRESS

Edmondson

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Probably gastric ulcer.*  
*Nonmalignant.*

62854 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST.; *10* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1206 Homewood Ave* St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*Male*

4-COLOR OR RACE,

*White*

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

*3 / 24 / 1922*  
(Month) (Day) (Year)

7-AGE,

yrs. mos. ds. *2*

If LESS than 1 day,

hrs. or min. *15*

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country),*Baltimore*

10-NAME OF FATHER,

*John H. Kelley*11-BIRTHPLACE OF FATHER  
(State or Country),*Md*

12-MAIDEN NAME OF MOTHER

*Bessie Byrne*13-BIRTHPLACE OF MOTHER  
(State or Country),*Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. H. Kelley*(Address) *1206 Homewood Ave*

15-

File

MAR 27 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*3 / 26 / 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*3 / 24 / 1922*, to *3 / 26 / 1922*,that I saw him alive on *3 / 26 / 1922*,and that death occurred, on the date stated above, at *8:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Apoplexy from Hemorrhage*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Hemorrhage from Catarrh*

(Duration) yrs. mos. ds.

(Signed) *Bernard Weiss* M. D., 101... (Address) *914 E. Biddle*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*Cathedral* *Mar 27 1922*

20-UNDERTAKER ADDRESS

*H. C. Wiedefeld 914 Green Mt*

N. B.—Every item of information on back of certificate. Exact statement of occupation in plain terms, so that it may be properly classified. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62855

## CERTIFICATE OF DEATH.

REGISTERED NO.

D 62855

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4201 Euclid Ave ST. 70 WARD)

## 2-FULL NAME

Herman Kassarakis

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE. No.

4201 Euclid Ave

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. 3 mos. 7 ds. How long in U. S., if of foreign birth? 54 yrs. 3 mos. 7 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Katherine Kassarakis

6 DATE OF BIRTH (month, day, and year) Nov 18 = 1847

7 AGE Years 74 Months 3 Days 7 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Mechanical

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

## PARENTS

14 Informant Herman Kassarakis (Address) 4201 Euclid Ave

## 15

6261 23821 ROBERT R. KRAUTER, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1922

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1922, to March 25, 1922, that I last saw him alive on March 24, 1922, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH\* was as follows:

Acute Myocardial Insufficiency (duration) 1 yr. 3 mos. 7 ds. CONTRIBUTORY (Secondary) Chronic Myocarditis (duration) 1 yr. 3 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W. Jones, M. D.

3.27.19 (Address) 2216 Euclid Ave

\*State the Disease Causing Death, or in cases from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Landon Park Cemetery Mar 28 1922

20 UNDERTAKER

ADDRESS

H. B. Huppert 2216 Euclid Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 62856

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62856

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 323 S. Moodyear, ST. 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 323 S. Moodyear

St.; 32 yrs., 1 mo., 1 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married (Write the word.)

6-DATE OF BIRTH. Dec 4, 1866 (Month) (Day) (Year)

7-AGE. 55 yrs., 3 mos., 21 ds. If LESS than 1 day, ....hrs. or....min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Wagon Builder (b) General nature of industry, business, or establishment in which employed (or employer). 016

## 9-BIRTHPLACE, (State or Country),

Germany

## 10-NAME OF FATHER,

John Babkowski

## 11-BIRTHPLACE OF FATHER (State or Country),

Germany

## 12-MAIDEN NAME OF MOTHER

Unknown

## 13-BIRTHPLACE OF MOTHER (State or Country),

Germany

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederica Babkowski

(Address) 323 S. Moodyear St.

## 15-

Robert B. Harrison, Filed 191. Registrar.

27 1922 Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 25, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 16, 1922, to March 25, 1922, that I saw him alive on March 25, 1922, and that death occurred, on the date stated above, at 12-15 P. m.

The CAUSE OF DEATH\* was as follows:

Recurring Cerebral Hemorrhage

(Duration) yrs. mos. ds. CONTRIBUTORY Chronic Interstitial Nephritis (Secondary) (Duration) yrs. mos. ds.

(Signed) Henry C. Ober M. D. March 25, 1922 (Address) 1203 N. Fayette St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Western Cem.

## DATE OF BURIAL,

....., 191...

## 20-UNDERTAKER

H. Witzke

## ADDRESS

15-31 W. Lane

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62857

62857

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *28 W. Cross* ST.; *23* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *James Thomas*(Residence in Baltimore: No. *28 W. Cross Ave* St. *15* yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*male*

4-COLOR OR RACE,

*colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH,

*Aug 9 1866*  
(Month) (Day) (Year)

7-AGE,

*36*

yrs. mos. ds.

If LESS than 1 day,  
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *laborer*  
(b) General nature of industry, business, or establishment in which employed (or employer) *040*9-BIRTHPLACE,  
(State or Country), *va*

10-NAME OF FATHER,

*James B. Thomas*11-BIRTHPLACE OF FATHER,  
(State or Country), *va*12-MAIDEN NAME OF MOTHER *un known*13-BIRTHPLACE OF MOTHER  
(State or Country), *un known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Maggee Thomas*(Address) *28 W. Cross St*

15-

*Robert P. Harrison,*

Filed

191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*March 25 1912*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *March 11 1912* to *March 25 1912*,that I saw him alive on *March 24 1912*,and that death occurred, on the date stated above, at *11:20 p.m.*

The CAUSE OF DEATH\* was as follows:

*fractured ribs*CONTRIBUTORY  
(Secondary) *Do. A. Harrison*(Duration) yrs. mos. ds. *14*(Signed) *W. H. Harrison* M. D.*March 22, 1912* (Address) *712 S. Park*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

*Mt. Auburn*

DATE OF BURIAL,

*March 28, 1912*

20-UNDERTAKER

*J. H. Brown*

ADDRESS

*108 W. Main*

B.—Every item of information should be carefully supplied in plain terms, so that it may be properly classified. Exact statement of OCCUPATION, CAUSE OF DEATH, and RESIDENCE, if different from place of death, is important. See instructions on back of certificate.

MAR 27 1922

Burial Board Clerk. Registrar.

D 62858

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62858

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *12* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs. Mary McNeill*(a) RESIDENCE. No. *2426 North Calvert* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *31* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,

or Divorced (write the word)

*Female**White**Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Mr. Richard McNeill*

6 DATE OF BIRTH (month, day, and year)

*Sept 28, 1857*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*65 5 28*

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Housewife*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Ind.*

10 NAME OF FATHER

*James Redwood*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Ind.*

12 MAIDEN NAME OF MOTHER

*Mary Lupton*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Ind.*

14

Informant  
(Address)*Mercy Hospital Records*

15

AR 2 7 1922

*Robert P. Harrison**Burial Permit Clerk*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*March 26, 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 17, 1922, to March 26, 1922*that I last saw her alive on *March 26, 1922*and that death occurred, on the date stated above, at *9:28 P.M.*

The CAUSE OF DEATH\* was as follows:

*Cholelithiasis and  
Chronic Interstitial Nephritis*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)*Myocarditis & Arteriosclerosis*

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?*Home*Did an operation precede death? *Yes* Date of *March 13, 1922*Was there an autopsy? *Yes*What test confirmed diagnosis? *Findings at operation & Physical*(Signed) *John F. Green* M. D.Address *Mercy Hospital*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mechanics Vile**March 29, 1922*20 UNDERTAKER *W. Hays Co. Inc.* ADDRESS*for Frederick & Son* *217 S. Bow*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62859

## CERTIFICATE OF DEATH.

D 62859

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 S. Calhoun St. WARD) 192-FULL NAME Moses. C. Gosnell

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 126 S. Calhoun St. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. c mos. c ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Married Single, Married, Widowed, or Divorced (write the word)5a If married, widowed, or divorced HUSBAND of Rebecca Gosnell (or) WIFE of6 DATE OF BIRTH (month, day, and year) Feb 14 18547 AGE Years 68 Months 1 Days 11 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 192217 I HEREBY CERTIFY, That I attended deceased from March 22 1922 to March 20 1922, that I last saw him alive on March 24 1922.and that death occurred, on the date stated above, at 3 30 a.m.

The CAUSE OF DEATH\* was as follows:

Acute Articular RheumatismCONTRIBUTORY (Secondary) Acute Glomerulonephritis (duration) 1 yrs. 4 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 2Was there an autopsy? 2

What test confirmed diagnosis?

(Signed) J. P. Harrison M. D. 19 22 Address 1735 Hollister St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Olivet CemMarch 28 1922

20 UNDERTAKER

ADDRESS

Jos. Frederickson, Son2178 Pa

N. B.—WRITE PLAINLY, WITH CARE. Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

MAR 27 1922

Burial Permit Clerk,

D 62860

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62860

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE (No. 1600 Park N. Math Ave., St. 15 WARD)2-FULL NAME Ada H. Reed(Residence in Baltimore: No. 1627 Ashburton Ave., St. 4 yrs. 9 mos. 21 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-SINGLE, Single  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)6-DATE OF BIRTH, March 5, 1916  
(Month) (Day) (Year)7-AGE, 6 yrs. 2 mos. 21 ds. If LESS than 1 day,  
...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,  
(State or Country), New York10-NAME OF FATHER, Wm. A. Reed11-BIRTHPLACE OF FATHER  
(State or Country), Arkansas12-MAIDEN NAME OF MOTHER Helen Palmer13-BIRTHPLACE OF MOTHER  
(State or Country), N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. A. Reed(Address) 1627 Ashburton Ave.

15-

Filed Robert P. Harrison,  
191

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 26, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest  
(Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said inquest  
(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Fracture of skull  
(Duration) ... yrs. ... mos. ... ds.CONTRIBUTORY Automobile accident  
(Secondary)(Signed) J. T. Harrison M. D.  
(Coroner.)March 27, 1922 (Address) 2802 E. Broadway

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the  
of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

B. Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assoc.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as *accidental*, *suicidal*, or *homicidal*, or as *probably such*. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No other abnormal  
condition.*



D 62862

HEALTH DEPARTMENT—CITY OF BALTIMORE

62862

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 Born ST., 18 WARD)

## 2. FULL NAME

Emanuel Pien

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1103 Born

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

MBSingle5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Jan. 24-1919

7 AGE

3

Years

Months

2

Days

1If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

MAR 27 1922

Robert P. Hartman,

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25 1922

17

I HEREBY CERTIFY, That I attended deceased from

Mar 15<sup>th</sup> 1922 to Mar 25 1922that I last saw him live on Mar 25 1922and that death occurred, on the date stated above, at 5 P.m.

The CAUSE OF DEATH\* was as follows:

Nephritis6 mo (duration) yrs. 6 mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Visible(Signed) H. Manger M. D.19 (Address) 1002 Edenboro

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Andrew'sMar 28 1922

20 UNDERTAKER

ADDRESS 114 W.Brown & EnglandSchneider

Information should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No other abnormal  
condition*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62863

D 62863

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH 911 West Franklin Street

CITY OF BALTIMORE: (No. 911 West Franklin

ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Patterson

(a) RESIDENCE NO. 911 West Franklin Street

(Usual place of abode) Length of residence in city or town where death occurred 28 yrs. mos. ds.

(If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of Samuel Purdy Patterson

6 DATE OF BIRTH (month, day, and year) Nov. 22, 1857

7 AGE Years 65 Months 8 Days 3 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Plainfield, N.J. (State or country)

10 NAME OF FATHER Moses Phillipot

11 BIRTHPLACE OF FATHER (city or town) England (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) England (State or country)

14 Informant Earl S. Patterson (son) (Address) 911 West Franklin Street.

15 Filed Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 19 22

17 I HEREBY CERTIFY, That I attended deceased from March 25 19 22 to March 25 19 22

that I last saw him or alive on March 25 19 22

and that death occurred, on the date stated above, at 1:50 p. m.

The CAUSE OF DEATH\* was as follows:

Apoplexy.

CONTRIBUTORY Hemiplegia, left. (duration) yrs. mos. ds. (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John P. Morgan, M. D. 3/25/22 (Address) 1002 Edmondson Avenue.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Exact statement of OCCURRENCE should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

R 27 1922

D 62864

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62864

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1805 Jefferson* ST., *6* WARD)2-FULL NAME *Caterina Dantons*(a) RESIDENCE NO. *1805 Jefferson* ST.,

(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs. mos. ds.(If non-resident give city or town and State)  
How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*white*

5 Single, Married, Widowed, or Divorced, (write the word)

*widow*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *February 1843*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*79*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Italy*

10 NAME OF FATHER

*Andrew Dantons*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Italy*

12 MAIDEN NAME OF MOTHER

*Rosa Liberto*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Italy*

14

Informant  
(Address)*Jam. D'Angelo  
1805 Jefferson St.**Robert H. Clark*

19

*Permit Clerk*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 26 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar 24 1922* to *Mar 26 1922*that I last saw *her* alive on *Mar 26 1922*and that death occurred, on the date stated above, at *2 P. m.*

The CAUSE OF DEATH\* was as follows:

*apoplexy*CONTRIBUTORY (Secondary) *Chronic Interstitial Nephritis*  
(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Luigi D. Di Stefano* M. D.27 1922 (Address) *407 W. E. St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL*St. Vincent's Cemetery*

20 UNDERTAKER

*George J. Ruth*

DATE OF BURIAL

*3/28 1922*

ADDRESS

*1735 Harford St.*

Information should be carefully supplied. AGE must be given in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

A27 1922



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62865

## CERTIFICATE OF DEATH.

179 D 62865

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *605 N castle* ST., *7* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Matilda A. Hoehn*(a) RESIDENCE NO. *605 N castle*

(Usual place of abode)

ST.,

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *57* yrs. mos. ds.How long in U. S., if of foreign birth? *57* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female white widower*5a If married, widowed, or divorced? HUSBAND of (or) WIFE of *Michael Hoehn*6 DATE OF BIRTH (month, day, and year) *July 25 1865*

7 AGE

*76* Years

Months

*8*

Days

*1*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*House wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *John Durrell*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Germany*12 MAIDEN NAME OF MOTHER *Not known*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Germany*

## PARENTS

14 Informant *Michael A. Hoehn*(Address) *605 N castle st*

15

*Robert P. Harrison*

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 26 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Sept*, 19*22*, to *March*, 19*22*.that I last saw him alive on *March 24*, 19*22*.and that death occurred, on the date stated above, at *3 A.* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Nephritis*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

*Chronic Nephritis*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Frank J. Ayer*

M. D.

1922

(Address)

*2005 E. Mount St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVING

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*James C. Miller**2534 Jefferson St*

AR 27 1922

Burial Permit Clerk:

D 62866

HEALTH DEPARTMENT—CITY OF BALTIMORE

62866

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No.

Lombard + Gorman

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Joseph S. Baker

(a) RESIDENCE. NO.

Cockeysville, Md.

ST.

WARD.

Cockeysville Md.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 2 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

4 20

1913

7 AGE

8

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

Apr

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Schoolboy

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Md.

10 NAME OF FATHER

Joseph N. Baker

11 BIRTHPLACE OF FATHER (city or town)

Md.

(State or country)

12 MAIDEN NAME OF MOTHER

Imma Standiford

13 BIRTHPLACE OF MOTHER (city or town)

Md.

(State or country)

14

Informant  
(Address)Joseph Baker  
3311 Beart Ave

15

Filed

Robert P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/26/1922

17

I HEREBY CERTIFY, That I attended deceased from

2/4

1922, to

3/26

1922

that I last saw him alive on

3/26

1922

and that death occurred, on the date stated above, at

10<sup>21</sup>P.m.

The CAUSE OF DEATH\* was as follows:

Septic Meningitis caused by a  
Klebsiella Bacillus

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

home

Did an operation precede death?

yes

Date of 3/26/22

Was there an autopsy?

no

What test confirmed diagnosis?

clinical findings

(Signed)

J. W. B. Jones

M. D.

19

(Address)

University Hospital

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Market Ball Co

Mar 29 1922

20 UNDERTAKER

E. L. Roy Stipples

ADDRESS

1258 North Ave

R 27 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62867

D 62867

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mr Hope Retreat*)ST.: *28* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mary King*3-RESIDENCE. NO. *Mr Hope Retreat*

(Usual place of abode)

ST.: *28* WARD. *Delaware*

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *11* yrs. *?* mos. *?* ds. How long in U. S., if of foreign birth? *24* yrs. *11* mos. *1* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Single*6 DATE OF BIRTH (month, day, and year) *about-1898*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *24*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*(b) General nature of industry, business, or establishment in which employed (or employer) *None*(c) Name of employer *None*9 BIRTHPLACE (city or town) (State or country) *Unknown*10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Unknown*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*14 Informant *Mr Hope Retreat* (Address) *100*15 *27* 1922 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 27* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *Apr 13*, 19*22*, to *March 27*, 19*22*, that I last saw her alive on *March 26*, 19*22*, and that death occurred, on the date stated above, at *11:30 a.* m. The CAUSE OF DEATH\* was as follows:*Heart Disease*

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death? *Delaware*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Frank J. Flannery*, M. D., 19 (Address) *Mr Hope Retreat*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Catholic Cemetery**May 28* 19*22*20 UNDERTAKER *STEWART & MOWEN COMPANY*

ADDRESS

(WILLIAM F. WOODEN, Successor)

*108 W. NORTH AVE.*

Information should be carefully supplied. Exact statement of OCCUPATION, CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62868

## CERTIFICATE OF DEATH.

45 D 62868

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Cottage Bldg. Baker, Bkly* ST. *16* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *Longwood & Baker st* St. *78* yrs., *10* mos., *27* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*  
(Write the word.)

6-DATE OF BIRTH, *May 16*, *1843*  
(Month) (Day) (Year)

7-AGE, *78* yrs., *10* mos., *27* ds. If LESS than 1 day, .... hrs. or .... min.

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *None*  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Balto Md*

10-NAME OF FATHER, *Gas R Lsmall*

11-BIRTHPLACE OF FATHER (State or Country), *Balto Md*

12-MAIDEN NAME OF MOTHER *Harriett Albright*

13-BIRTHPLACE OF MOTHER (State or Country), *Balto Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *H J Waltry*

(Address) *Longwood & Baker*

15-

Filed *Robert* 191 *HART*

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *March 27*, *1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Apr 4<sup>th</sup>* *1922* to *March 27* *1922* that I saw her alive on *March 27* *1922* and that death occurred, on the date stated above, at *10* m.

The CAUSE OF DEATH\* was as follows:

*Substernal Carcinoma*

(Duration) *3* yrs., *3* mos., *3* ds.

CONTRIBUTORY (Secondary) *None*

(Duration) *3* yrs., *3* mos., *3* ds.

(Signed) *Chas S Parker* M. D.

*3/27*, *1922* (Address) *3123 W. North*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *3* yrs., *3* mos., *3* ds. In the State *3* yrs., *3* mos., *3* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

*Lorraine Ave* *March 30*, *1922*

20-UNDERTAKER ADDRESS

*Wm Cook* *502 E. North*

B.—Every citizen of Baltimore is important. See instructions on back of certificate.

7 1922



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62869

## CERTIFICATE OF DEATH.

D 62869

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 660 W. Franklin ST.: 17 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Alice Hopkins(a) RESIDENCE. NO. 660 W. Franklin ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Scott Hopkins6 DATE OF BIRTH (month, day, and year) Feb 14 - 18467 AGE Years 76 Months 1 Days 13 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)10 NAME OF FATHER Lamphear11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)12 MAIDEN NAME OF MOTHER Rigby13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)14 Informant Mr Harry Hopkins (Address) 660 W. Franklin15 MAR 28 1922 ROBERT A. KRANTZ Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/26 19 2217 I HEREBY CERTIFY, That I attended deceased from Mar 16/22 19 to Mar 26/22 19 22 that I last saw her alive on Mar 26 19 22 and that death occurred, on the date stated above, at 7 P. m. The CAUSE OF DEATH\* was as follows:Pneumonia(duration) yrs. mos. 10 ds.CONTRIBUTORY Pulmonary Embolism (Secondary)(duration) yrs. mos. 3 ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? No Date of —Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Gustav Goldmann M. D., 19 (Address) 660 W. Franklin

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Frederick Park Cemetery March 28 1922

20 UNDERTAKER

H. M. Routson

ADDRESS

230 N Greene St

mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D 62870  
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 George

ST. 17

WARD)

2-FULL NAME George W. Towson

(a) RESIDENCE. No. 615 George

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs.

ST.

WARD.

(If nonresident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male Colored Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Lottie Towson

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

68

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Expressman 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER Robt Towson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER Edith Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Mrs Lottie Towson 615 George St

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1922

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1922, to March 26, 1922, that I last saw him alive on March 25, 1922, and that death occurred, on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH\* was as follows:

Pneumonia &amp; Lobar

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis Pharyngeal lymphatic

(Signed)

Address

712 S. Park St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn

March 25 1922

20 UNDERTAKER

John H. Toadwin W. Hill

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62871

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 E Lee St.)

ST.: WARD)

## 2-FULL NAME

(a) RESIDENCE. NO. 21 E Lee St.

(Usual place of abode)

Length of residence in city or town where death occurred

90 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Negro

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Geo Smith

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Greenstown Md

10 NAME OF FATHER

Geo Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Greenstown Md

12 MAIDEN NAME OF MOTHER

Mary Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Greenstown Md

14 Informant (Address)

Midast Palmer 210 E Lee St

15 Filed

19

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/27 1922

17

I HEREBY CERTIFY, That I attended deceased from

Dec 14, 1921, to Mar 27, 1922

that I last saw her alive on 3/26, 1922

and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH\* was as follows:

Massive

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Balto Md

Did an operation precede death?

no

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. R. Bayler, M. D.

1615 Calhoun

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt Auburn

DATE OF BURIAL

Mar 30 1922

20 UNDERTAKER

John H. Tradine

ADDRESS

142

MAR 28 1922

D 62872

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62872

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 20 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

61 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Kate Ainey

6 DATE OF BIRTH (month, day, and year)

Feb 22 1881

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

61

1

5

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Saborey

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Hiram Ainey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Mary E. Staley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

Kate Ainey

1929 Vine St

15

Filed

MAR 28 1922

ROBERT R. KRASTEN,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAR 27 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 20, 1922, to March 27, 1922,

that I last saw him alive on March 27, 1922,

and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Joseph J. Schaefer, M. D.

, 19 (Address) 1576 Madison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western

MAR 30 1922

20 UNDERTAKER

ADDRESS

Geo W Little

2700 Edmondson Ave



D 62873

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 D 62873

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital* ST.: *7* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs. Rose Koshland*(a) RESIDENCE. NO. *Hebrew Hospital* ST.: WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred *55* yrs. mos. ds. How long in U. S., if of foreign birth? *60* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Isaac Koshland*6 DATE OF BIRTH (month, day, and year) *Mar 10 / 1843*7 AGE Years *78* Months *9* Days *17* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *Samuel Koshland*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*14 Informant *R. Koshland* (Address) *Baltimore*

MAR 28 1932

ROBERT R. KAUFMAN Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/27/22* 1917 I HEREBY CERTIFY, That I attended deceased from *3/23/22*, 19, to *3/27/22*, 19, that I last saw her alive on *3/27/22*, 19, and that death occurred, on the date stated above, at *5:30 P* m. The CAUSE OF DEATH\* was as follows:*Acute Cardiac Dilatation*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Chr. Myocarditis*

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *S. Zinberg*, M. D.*3/27, 19* Address *Hebrew Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Hebrew Burial Society* *Mar 29* 1932

20 UNDERTAKER ADDRESS

*Davidson & Sons* *1111 N. Broadway*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62874

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 D 62874

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST. 13 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Residence in Baltimore: No.

St. 6 U.S. 34 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White MARRIED Married

DATE OF BIRTH March 3, 1875

AGE 47 yrs. 24 ds. or min.?

OCCUPATION Retired

BIRTHPLACE Russia

NAME OF FATHER Simon A. Cohen

BIRTHPLACE OF FATHER Russia

MAIDEN NAME OF MOTHER Malk. Katz

BIRTHPLACE OF MOTHER Russia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Deborah Cohen

(Address) 3415 Beech Ave

MAR 28 1922 ROBERT R. KRAUTER,

Filed 1922 Burial Form REGISTAR

DATE OF DEATH Mar. 27, 1922

I HEREBY CERTIFY, That I attended deceased from Mar. 20, 1922, to Mar. 27, 1922, that I saw him alive on Mar. 27, 1922, and that death occurred, on the date stated above, at 9.05 A.m. The CAUSE OF DEATH\* was as follows:

Pneumo-pneumonia

Contributory (SECONDARY)

(Signed) J. A. Dodds M. D. Mar. 27, 1922 (Address) 3101 Clifton Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted. If not at place of death? Former or usual residence

PLACE OF BURIAL OR REMOVAL Bonae Israel DATE OF BURIAL 3-28-22

UNDERTAKER David Sandheim ADDRESS 25 Mt Royal

D 62875

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62875

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1651 N. Appleton

ST. 15 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bettie Eichberg

(a) RESIDENCE. NO. 1651 N. Appleton  
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. da. How long in U. S., if of foreign birth? 30 yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Meyer Eichberg

6 DATE OF BIRTH (month, day, and year) March 15 1859

7 AGE 63 Years Months Days If LESS than 1 day, hrs. or min. 10

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work 137

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Germany

10 NAME OF FATHER

John Goldschlager

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Germany

14

Informant Meyer Eichberg  
(Address) 1651 N. Appleton

15

MAR 28 1922

ROBERT R. KRAUTER,

Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1922

17

I HEREBY CERTIFY, That I attended deceased from September, 1921, to March 25, 1922, that I last saw her alive on March 25, 1922, and that death occurred, on the date stated above, at 2 P.M. m. The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

(duration) 12 mos. ds.

CONTRIBUTORY Tubercular Infection in abdomen!  
(Secondary) (duration) 12 mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symplicious

(Signed) Howard C. Silver, M. D.

, 19 (Address) 3706 Liberty Heights av

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Friendship

3-28 1922

20 UNDERTAKER

ADDRESS

David Sandheim 118 W. Royal

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

### PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital)

2-FULL NAME MARY MAGRUDER MAYNARD

(Residence in Baltimore: No. 307-W-Lanvale-St.)

ST. 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

72-3-8

St.; yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED

Married

WIDOWED

OR DIVORCED

(Write the word.)

6-DATE OF BIRTH,

DECEMBER

18

1849

(Month)

(Day)

(Year)

7-AGE,

72

3

8

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

BALTIMORE, Md.

10-NAME OF

FATHER,

HENRY HILLEARY

11-BIRTHPLACE

OF FATHER

(State or Country),

MARYLAND

12-MAIDEN NAME

OF MOTHER

MATILDA MAGRUDER

13-BIRTHPLACE

OF MOTHER

(State or Country),

MARYLAND

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard D. Maynard (husband)

(Address) 307-W-Lanvale-St.

15-

MAR 28 1922

ROBERT R. KRAUTER

Burial Permit Clerk

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, au-

inquest find that said deceased came to death (Inquest, au-  
topsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Fract. skull caused  
by accidentally running a  
walking against a  
bar of rail in street  
(Duration) about 1 1/2 hrs. yrs. mos. ds.

CONTRIBUTORY

(Secondary)

about 1 1/2 hrs. yrs. mos. ds.

(Signed) W. H. H. H. M. D.

(Coroner) W. H. H. H.

191. 7 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 half-hrs. 3 mos. 8 ds.

Where was disease contracted, if not at place of death?

North Av-Charles St.

Former or usual residence 307-W-Lanvale-St.

19-PLACE OF BURIAL OR REMOVAL.

St. Thomas, Garrison Forest

DATE OF BURIAL, Mar-29-22

ADDRESS

108 W. NORTH AVE

20-UNDERTAKER

STEWART & MOWEN COMPANY

(WILLIAM F. WOODEN, Successor)



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62877

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 321-East-University Parkway: 12 WARD)

## 2-FULL NAME

Thomas James Tull

(a) RESIDENCE. No 321-E-University Parkway ST., 12 WARD. (Resident)  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 59 yrs 7 mos 0 ds. How long in U. S., if of foreign birth? 59 yrs 7 mos 0 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX MALE 4 COLOR OR RACE WHITE 5 Single, Married, Widowed, or Divorced (write the word) MARRIED

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Griffin Robinson Tull

6 DATE OF BIRTH (month, day, and year) Aug-26-1862

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
59 7 0

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sec'y-Treas of the

(b) General nature of industry, business, or establishment in which employed (or employer) A. F. Lawrence Coal Co

(c) Name of employer The A. F. Lawrence Coal Co

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER Thomas James Tull

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Somerset Co., Md.

12 MAIDEN NAME OF MOTHER Caroline E. Warner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) St. Johnburg Vermont

14 Informant Myron G. Tull M.D. (son)

(Address) 321-E-University Parkway, City

15 Filed MAR 28 1922 ROBERT R. KRAEGER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1922

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1922, to March 26, 1922

that I last saw him alive on March 26, 1922

and that death occurred, on the date stated above, at 12:30 P. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Abscess, from  
Tubercular Pneumonia.CONTRIBUTORY (duration) yrs. mos. 18 ds.  
Chronic Emphysema  
(Secondary) + Bronchitis (duration) unknown ds.18 Where was disease contracted  
if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry E. Tull, M. D.

, 19 (Address) 1100 E. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

LOUDON PARK CEMETERY

MARCH-28-22

20 UNDERTAKER

STEWART & MOWEN COMPANY  
(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.

Information should be carefully supplied, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62878

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *North Hope Retmar* ST. *288* WARD)2-FULL NAME *Frank J. Falvey*(a) RESIDENCE. NO. *North Hope Retmar*  
(Usual place of abode)ST. *288* WARD. *New York City*

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *6* yrs. *2* mos. *0* ds. How long in U. S., if of foreign birth? *Life* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*Single*6 DATE OF BIRTH (month, day, and year) *about-1886*7 AGE Years *36* Months *0* Days *0* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Stenographer*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Book work & clerking*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*New York City*  
*New York*

10 NAME OF FATHER

*Thomas Falvey*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *New York City*  
*New York*

12 MAIDEN NAME OF MOTHER

*Catherine Buechel*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *New York City*  
*New York*

14

Informant  
(Address)*Records of North Hope Retmar*  
*North Hope Retmar*

15

*MAR 28 1922**ROBERT B. KRAUTER,*  
Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 25, 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 16<sup>th</sup>, 1916, to March 25, 1922*that I last saw him alive on *March 22, 1922*and that death occurred, on the date stated above, at *7:30 a. m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Gastro-Enteritis**abr*(duration) *2* yrs. *0* mos. *0* ds.CONTRIBUTORY  
(Secondary)*Dementia Praecox**abr*(duration) *6* yrs. *0* mos. *0* ds.18 Where was disease contracted  
if not at place of death?*New York City*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Frank J. Falvey*, M. D., 19 (Address) *North Hope Retmar*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*New York - N. Y.*

DATE OF BURIAL

*Mar 28/22*

20 UNDERTAKER

*STEWART & MOWEN COMPANY*  
(WILLIAM F. WOODEN, Successor)

ADDRESS

*108 W. NORTH AVE.*

Information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 62879 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62879

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1829 Bolton

ST.: 14 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy B. Kearney

(a) RESIDENCE. No. 1829 Bolton

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred (yrs. 23) mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female White Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

James B. Kearney

6 DATE OF BIRTH (month, day, and year) Dec. 2<sup>nd</sup> 1862

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

60 3 20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 039

(b) General nature of industry, business, or establishment in which employed (or employer)

" "

(c) Name of employer

9 BIRTHPLACE (city or town) Lancaster Penna.  
(State or country)

10 NAME OF FATHER Cyrus Bush

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Pa.

12 MAIDEN NAME OF MOTHER Mary Ann

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Pa.

14 Informant Jas. R. Kearney  
(Address) 1829 Bolton St.

15 Filed MAR 28 1922 ROBERT R. KRAUTER, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25<sup>th</sup> 1922

17 I HEREBY CERTIFY, That I attended deceased from

January 1920, to March 25<sup>th</sup> 1922.that I last saw her alive on March 25<sup>th</sup> 1922.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH\* was as follows:

uterine Carcinoma

(duration) 2 yrs. mos. ds.

CONTRIBUTORY General Syphilis Toxicemia  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? Yes Date of  
Radium treatment

Was there an autopsy? No

What test confirmed diagnosis? Radiation

(Signed) Howard B. Silver M. D.

, 19 (Address) 13706 Liberty Highway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park

Mar. 28 1922

20 UNDERTAKER

ADDRESS

Wm J. Tickner Sons N.Y. Pa.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62880

D 62880

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST., WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

12 72 1/2 Riverside ST.

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

male

## 4 COLOR OR RACE

white

## 5 Single, Married, Widowed, or Divorced, (write the word)

married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mellie B. Argue

## 6 DATE OF BIRTH (month, day, and year)

3/18/78

## 7 AGE

43

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

Plumbing Business

## (b) General nature of industry, business, or establishment in which employed (or employer)

059

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Ireland

## 10 NAME OF FATHER

Thomas Argue

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

## 12 MAIDEN NAME OF MOTHER

Margaret Jones

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

## 14

Informant (Address)

Mellie B. Argue 127 1/2 Riverside

## 15

Filed

MAR 28 1922

19

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

3/26 1922

## 17

I HEREBY CERTIFY, That I attended deceased from 3/12, 1922, to 3/26, 1922,

that I last saw him alive on 3/12, 1922,

and that death occurred, on the date stated above, at 2:15 p.m.

The CAUSE OF DEATH\* was as follows:

(Brain &amp; Lungs) Lymphangitis and Septicemia Carcinoma of the Prostate

(duration) yrs. mos. 26 ds.

## CONTRIBUTORY (Secondary)

Lymphangitis Septicemia Carcinoma of the Prostate

(duration) yrs. mos. 15 ds.

## 18 Where was disease contracted if not at place of death?

127 1/2 Riverside

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Boyd M. D.

19 (Address) 127 1/2 Riverside

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt. Olivet Cem

## 20 UNDERTAKER

J. F. McConally

## DATE OF BURIAL

3/29 1922

## ADDRESS

130 E. 7th

Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



MARYLAND GENERAL HOSPITAL

LINDEN AVE. & MADISON ST.

BALTIMORE, MARYLAND

GEO. CLARKE PECK,  
GENERAL SUPT.

W. J. COLEMAN, M. D.  
MEDICAL SUPT.

March 30th 1922.

Dept. of Health,  
Baltimore, Maryland.

Dear Sirs:

Please be advised that Mr. David Argue,  
deceased, was aged 43 years and eight days at the time  
of his death, instead of 44 years and eight days. (He  
was born March 18th, 1879. Our original information was  
incorrect.

Yours very truly,

*W. J. Coleman* M. D.

62881

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62881

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *112*)ST. *28* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. *112*

(Usual place of abode)

ST. *28* WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *44* yrs. *5* mos. *1* ds. How long in U. S., if of foreign birth? *44* yrs. *5* mos. *1* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Widow*

6 DATE OF BIRTH (month, day, and year)

*Unknown*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Domestic*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Ireland*

10 NAME OF FATHER

*Peter Jordan*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Ireland*

12 MAIDEN NAME OF MOTHER

*Bessie Sarnan*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Ireland*

14

Informant (Address)

*Friends of Mount Hope Park Baltimore Md*

15

MAR 28 1922

ROBERT A. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 27* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb. 17*, 19*22*, to *March 27*, 19*22*.that I last saw him alive on *March 26*, 19*22*.and that death occurred, on the date stated above, at *7:00* a. m.

The CAUSE OF DEATH\* was as follows:

*Gastritis*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Depressive Mania*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*Baltimore, Md*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Frank J. Flannery* M. D., 19 (Address) *112 Hope Street*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Peter Cemetery**March 29* 19*22*

20 UNDERTAKER

ADDRESS

*Henry Horch Sen**1301 E Bay St*

Information should be carefully supplied. Cause of death in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62882

62882

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2326 Stockton

2-FULL NAME

Thomas Freeland

(a) RESIDENCE. No. 2326 Stockton

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

Col

5 Single, Married, Widowed,  
or Divorced (write the word)

married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Annie Freeland

6 DATE OF BIRTH (month, day, and year)

1878

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

44

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Laborer

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)14 Informant  
(Address)

15 Filed

MAR 28 1922

ROBERT R. KRAUTER  
Registrar

Burial Permit Clerk

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

ST.: 15 WARD)

ST.: WARD.

(If nonresident give city or town and State)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/26/22

17

HEREBY CERTIFY, That I attended deceased from

2/29/22 to 3/25/22

that I last saw h. alive on 3/25/22 at 7:45 a.m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Mitral Regurgitation

CONTRIBUTOR

(Secondary)

nephritis

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

3/28/22

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62883

## CERTIFICATE OF DEATH.

153 D 62883

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1140 Vincent

ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs. Elizabeth Myers

(a) RESIDENCE. No. 1140 Vincent

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

William Myers

6 DATE OF BIRTH (month, day, and year) Mar 17 1870

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

52

0

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

Laundry 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Dorchester County Md.

10 NAME OF FATHER

James Long

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Dorchester Co. Md.

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Dorchester Co. Md.

14

Informant

(Address)

Mrs. Leah Haywood 221 N. Schreder St.

15

Filed

MAR 28 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 5 1922, to Mar. 26 1922,

that I last saw her alive on Mar 25 1922,

and that death occurred, on the date stated above, at 12:20 A. M.

The CAUSE OF DEATH\* was as follows:

Acute Multiple Abscess of Neck

(duration) yrs. 1 mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

yes Date of Feb. 5 1922

Was there an autopsy?

What test confirmed diagnosis?

Physical Signs

(Signed)

Jas. Edward Jell M. D.

19 (Address) 1224 N. Silver St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn Cem.

Mar 28 1922

20 UNDERTAKER

ADDRESS

David E. Carter

226



D 62884

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## 2/ CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 Peirce ST., 18 WARD)

## 2-FULL NAME Sarah Knox

(a) RESIDENCE NO. 913 Peirce

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAR 28 1922

ROBERT N. KRAUTER,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25, 1922

17

I HEREBY CERTIFY, That I attended deceased from March 23, 1922, to March 25, 1922

that I last saw her alive on March 25, 1922

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH\* was as follows:

Influenza

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? to Date of

Was there an autopsy? to

What test confirmed diagnosis?

(Signed) Geo. W. Hemminger, M. D.

8-27-22 (Address) 800 Harbor

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62886

## CERTIFICATE OF DEATH.

179D 62886

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1824 Riggs Ave. ST., 27 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

## 6a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than 1 day, .... hrs. or min.

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

## Informant (Address)

## 15

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

## 17 I HEREBY CERTIFY, That I attended deceased from

March 20, 1922, to March 27, 1922,

that I last saw him alive on March 25, 1922,

and that death occurred, on the date stated above, at 7459.

## The CAUSE OF DEATH\* was as follows:

Perforation of liver

(duration) 1 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. 5 mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. C. Lumsden, M. D.

Date 27, 1922 (Address) 818 Park Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

MORAL

Address

William Beck 5028 North

Information should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARCH 28 1922

ROBERT A. KRAUTER,

Bureau Permit Clerk.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62887

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 E. Gibbons Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Hilscher(Residence in Baltimore: No. 4 E. Gibbons Ave St.; yrs. mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE.

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) married

## 6-DATE OF BIRTH.

December 23, 1883  
(Month) (Day) (Year)

## 7-AGE.

38 yrs. 3 mos. 4 da.

IF LESS than 1 day, hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Musician

## 9-BIRTHPLACE. (State or Country).

Balto. Md.

## 10-NAME OF FATHER.

Frank Hilscher

## 11-BIRTHPLACE OF FATHER. (State or Country).

Balto, Md.

## 12-MAIDEN NAME OF MOTHER.

Annie Ruzick

## 13-BIRTHPLACE OF MOTHER. (State or Country).

Bohemia

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Margaret Hilscher

(Address)

4 E. Gibbons Ave

## 15-

Filed

MAR 8 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

March 27, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from March 24, 1922, to March 27, 1922, that I saw him alive on March 27, 1922, and that death occurred, on the date stated above, at 8:00 m. The CAUSE OF DEATH\* was as follows:Diabetes Mellitusseveral  
(Duration) yrs. mos. da.

## CONTRIBUTORY (Secondary)

coma

(Duration) yrs. mos. da.

(Signed)

J. W. Keown M. D.Mar 27, 1922 (Address) 1908 Linden Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

Mt Olivet

## DATE OF BURIAL.

3/30, 1922

## 20-UNDERTAKER

## ADDRESS

Wm Coast 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.



# D 62888 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *520 Duncan*)

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

*Mary Venable*

(a) RESIDENCE. NO.

*520 Duncan*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

*4* mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*F*

4 COLOR OR RACE

*C*

5 Single, Married, Widowed, or Divorced (write the word)

*single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*February 27 1922*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*1*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*cool*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balto Md*

10 NAME OF FATHER

*Handy Venable*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Ward*

12 MAIDEN NAME OF MOTHER

*Mary Johnson*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Ward*

14

Informant (Address)

*Mary Johnson 520 Duncan St*

15

Filed

*MAR 8 1922*

ROBERT A. KRAUTER

Baptist Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*3/27*

1922

17

I HEREBY CERTIFY, That I attended deceased - from

*3/25*

1922, to

*3/27*

1922

that I last saw her alive on

*3/26*

1922

and that death occurred, on the date stated above, at

*5 A. M.*

The CAUSE OF DEATH\* was as follows:

*Acute meningitis (Lues Hereditaria)*

(duration)

yrs.

mos.

*2* ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

*unknown*

Did an operation precede death?

*no*

Was there an autopsy?

*no*

What test confirmed diagnosis?

*Physical & History*

(Signed)

*R. J. Johnson*

M. D.

, 19 (Address)

*122 E. Monument St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Adams Cemetery**28 March 1922*

20 UNDERTAKER

*Edward Bryson*

ADDRESS

*1631 Adams*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62889

D 62889

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.:

WARD)

2-FULL NAME

Mr John Tapscott

(a) RESIDENCE. NO.

Millenbeck

ST.:

WARD.

Va.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. If of foreign birth

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Cornelia Tapscott

6 DATE OF BIRTH (month, day, and year)

March 5/1859

7 AGE

67

Years

Months

Days

LESS than 1 day, hrs. or min.

22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Va

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Va

14

Informant (Address)

James Lemly 12832 Ripp Ave

15

Filed

MAR 8 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3-27 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 20, 1922 to 3-27, 1922

that I last saw him alive on 3-27, 1922

and that death occurred, on the date stated above, at 12:55 P. M.

The CAUSE OF DEATH\* was as follows:

Septicemia Thrombosis of femoral vein

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

Diabetes Mellitus

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Zimberg, M. D.

3/27/22 Address) Hebrew Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Millenbeck Virginia March 28, 1922

20 UNDERTAKER

ADDRESS

William Beck 5026 N. 1st St

Information should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

N. B.-Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT-CITY OF BALTIMORE

## CERTIFICATE OF DEATH

D 62890

PLACE OF DEATH

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. *111 E Randall*)  
2-FULL NAME *William Henry Myerly*  
(Residence in Baltimore: No. *111 E Randall*)

ST. *24* WARD)

Str. *48* yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*  
(Write the word)

6-DATE OF BIRTH *Aug 5, 1842*  
(Month) (Day) (Year)

7-AGE *79* yrs. *7* mos. *20* ds. or min.?  
If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work *Wheelwright*  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Manchester Carroll Co Md*

PARENTS  
10-NAME OF FATHER *Elias Myerly*  
11-BIRTHPLACE OF FATHER (State or country) *Maryland*  
12-MAIDEN NAME OF MOTHER *Not Known*  
13-BIRTHPLACE OF MOTHER (State or country) *Not Known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Edw E Myerly*  
(Address) *111 E Randall St*

15-ROBERT A. KRAUT  
Filed *MAR 8 1922* Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Mar 25, 1922*  
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *March 18<sup>th</sup> 1922* to *March 25<sup>th</sup> 1922*  
that I saw him alive on *March 24<sup>th</sup> 1922*  
and that death occurred, on the date stated above, at *9:50 A.M.*  
The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*  
(Duration) — yrs. — mos. *7* ds.

Contributory (SECONDARY) (Duration) — yrs. — mos. — ds.  
(Signed) *Harry Heibel*  
*Mar 25<sup>th</sup> 1922* (Address) *1224 Danover St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)  
At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.  
Where was disease contracted?  
If not at place of death?  
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *London Park* DATE OF BURIAL *Mar 18, 1922*

20-UNDERTAKER *John F. Denny* ADDRESS *715 Light*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62891

## CERTIFICATE OF DEATH.

D 62891

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (Name of city or town)

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

MAR 28 1922

ROBERT R. KRAUTER,

Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
March 18, 1922, to March 27, 1922,  
that I last saw her alive on March 27, 1922  
and that death occurred, on the date stated above, at 10.10 A. M.

The CAUSE OF DEATH\* was as follows:

Apoplexy  
Chronic Bright Disease + comp-  
lication Disease (duration) yrs. mos. 3 ds.CONTRIBUTORY Chronic Bright  
Disease (duration) 1 yrs. 1 mos. ds.18 Where was disease contracted  
if not at place of death? Roslyn Md.

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. W. H. H. M. D.

327 1922 Address 708 Enoch St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CITY OR RE- DATE OF BURIAL

Burial Bethel Heights Md. 28-22

20 UNDERTAKER ADDRESS

George H. Holland 1631 Howard Hill an



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62892

D 62892

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (IN)

## REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No.

St.; 2 yrs., 6 mos., da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

## 4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

## 6-DATE OF BIRTH

## 7-AGE

If LESS than 1 day, ... hrs. or ... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9-BIRTHPLACE, (State or Country),

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER (State or Country),

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER (State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

Filed

191

Burial Permit

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 12 1922 to March 26 1922

that I saw her alive on March 26 1922

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia (Bilateral)

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY Acute Bronchitis (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. S. McRae M. D.

3/27 1922 (Address) 1126 David Hill

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

## 20-UNDERTAKER

## ADDRESS

D 62893

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *409 Parish St.* ST. *19* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Maudie T. Ratcliff*(Residence in Baltimore: No. *409 Parish St.* St. *20* yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *Colored*5-STATUS  
MARRIED,  
UNMARRIED,  
OR SEVERED.  
(Write the word.) *Married*6-DATE OF BIRTH *Feb 22, 1866*

(Month)

(Day)

(Year)

7-AGE *56* yrs. *1* mos. *3* ds.

If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Laundress*(b) General nature of industry, business, or establishment in which employed (or employer) *41*9-BIRTHPLACE, (State or Country) *North Carolina*10-NAME OF FATHER *Unknown*11-BIRTHPLACE OF FATHER (State or Country) *Unknown*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (State or Country) *Unknown*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Elizabeth Johnson*(Address) *409 Parish St.*

## 15-

Filed *MAR 28 1922*

ROBERT R. KRAUTER,

Reg.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *March 20, 1922*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *March 1, 1922*, to *March 20, 1922*, that I saw her alive on *March 24, 1922*, and that death occurred, on the date stated above, at *2:27 p. m.*

The CAUSE OF DEATH\* was as follows:

*Paralysis Cerebral Hemiplegia*(Duration) .... yrs. .... mos. *27* ds.CONTRIBUTORY (Secondary) *As. Hemiplegia*(Duration) .... yrs. .... mos. *25* ds.(Signed) *W. H. Jones* M. D.*Wm. H. Jones* 1912. (Address) *712 S. Park St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Mid Auburn Mt. Mchls.*DATE OF BURIAL, *March 28, 1922*20-UNDERTAKER *George H. Holland*ADDRESS *1631 Conny*

N. B.—Every item of information should be in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62894

D 62894

## CERTIFICATE OF DEATH.

31

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Elizabeth's Home - Chestnut Hill Ave* ST.; *9* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Emma Pierson*

## (a) RESIDENCE. NO.

*St. Elizabeth's Home - Chestnut Hill Ave* ST.; *9* WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *3* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*female*

## 4 COLOR OR RACE

*negress*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Single*

## 6 If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Unknown*

## 7 AGE

*18 years*

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Institutional*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Ind Co. Ind.*

## 10 NAME OF FATHER

*Unknown*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ind Co.*

## 12 MAIDEN NAME OF MOTHER

*Unknown*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ind Co.*

## 14

Informant (Address)

*St. Elizabeth's Home - Chestnut Hill Ave*

## 15

File

MAR 28 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 27* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *March 1*, 19 *22*, to *March 25*, 19 *22*,that I last saw him alive on *March 25*, 19 *22*,and that death occurred, on the date stated above, at *6 A.* m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis*(duration) *unknown* yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *None*

(Signed)

*Frank J. Ayd*

M. D.

3/22 1922 Address *2005 E. Monument St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Cathedral Cem.**March 28* 19 *22*

## 20 UNDERTAKER

## ADDRESS

*George H. Holland**631 Duval St.*

CAUSE OF DEATH in plain terms, so that it may be properly certified. See instructions on back of certificates.

D 62895

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62895

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3058 Bethel

ST.: 2 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Harriett Mercer

## (a) RESIDENCE

No. 3058 Bethel

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? 2 mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

Caucasian

## 5 Single, Married, Widowed, or Divorced (write the word)

Widowed

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Widowed

## 6 DATE OF BIRTH (month, day, and year)

Unknown

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

62

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Work 070

(b) General nature of industry, business, or establishment in which employed (or employer)

House Work

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Cecil County Md

## 10 NAME OF FATHER

Joshery Smith

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Cecil County Md

## 12 MAIDEN NAME OF MOTHER

Harriett Smith

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Cecil County Md

## 14

Informant (Address)

Estelle Sinclair 3058 Bethel St

## 15

MAR 28 1922 ROBERT P. KRAUTER Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-26-22

## 17

I HEREBY CERTIFY, That I attended deceased from

Mar 13th 1922, to Mar 26th 1922

that I last saw her alive on Mar 25, 1922

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH\* was as follows:

Nephritis

over

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine Exam.

(Signed) Jacob L. Winson, M. D.

327 1922 (Address) 3058 B. Way

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Bohemian Manor Cemetery

## DATE OF BURIAL

March 29 1922

## 20 UNDERTAKER

Mrs Robert A Elliott

## ADDRESS

1725 Ashland St

Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No other abnormal  
condition than cold*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62896

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Brown(a) RESIDENCE. NO. Unknown 618 Bethel ST. 7 WARD(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.  
(If resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Unknown5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 1859  
7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
62 -- -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown  
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown  
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)14 Informant Hospital Records,  
(Address) Municipal Hospital.15 MAR 28 1922 ROBERT R. KRAUTER  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25, 192217 I HEREBY CERTIFY. That I attended deceased from February 23 1915 to March 25 1922.  
that I last saw her alive on March 25, 1922.  
and that death occurred, on the date stated above, at 5:20 A.M.  
The CAUSE OF DEATH\* was as follows:Chronic myocarditisCONTRIBUTORY Arteriosclerosis  
(Secondary) (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Autopsy(Signed) Clyde M. Munn M. D.3/25/22 Address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mont AuburnMarch 28 1922

20 UNDERTAKER

ADDRESS

John H. Owen538 Baltimore

Information should be carefully supplied. Also, should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 62897

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62897

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1609 M. E. Culloch ST.* WARD *14*)2. FULL NAME *John Liles*(a) RESIDENCE NO. *1609 M. E. Culloch ST.* WARD *14*

(Usual place of abode)

Length of residence in city or town where death occurred *40* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *Colored*5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Caroline Liles*6 DATE OF BIRTH (month, day, and year) *Oct. 17, 1866*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. *6 8*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Fireman*(b) General nature of industry, business, or establishment in which employed (or employer) *Stationary*(c) Name of employer *Free Country*9 BIRTHPLACE (city or town) (State or country) *MD*10 NAME OF FATHER *John Liles*11 BIRTHPLACE OF FATHER (city or town) (State or country) *MD*12 MAIDEN NAME OF MOTHER *Antonia*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *MD*

14

Informant (Address) *Wm. L. Liles*

15

Filed

MAR 28 1922

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 10 - 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan. 10th 1922* to *Nov. 10th 1922*that I last saw him alive on *Nov. 20th 1922*and that death occurred, on the date stated above, at *310*

The CAUSE OF DEATH\* was as follows:

*Organic heart disease*(duration) yrs. *3* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *No* Date of *✓*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *A. Lee Ellis*, M. D.(Address) *924 M. E. Culloch St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOV.

*St. Anthony Cemetery*

20 UNDERTAKER

*Jos. M. Johnson*

DATE OF BURIAL

*Nov. 28, 1922*

ADDRESS

*1234 Etting St.*

Exact statement of occurrence should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62898

## CERTIFICATE OF DEATH.

31 D 62898  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE, (NO. 623 Barrett Ave. 9

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 623 Barrett av

St.; yrs., mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female	4-COLOR OR RACE White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married
6-DATE OF BIRTH Sept 20, 1883 (Month) (Day) (Year)		
7-AGE 38 yrs. 6 mos. 5 ds. If LESS than 1 day, ... hrs. or ... min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Housewife		
9-BIRTHPLACE, (State or Country), Baltimore		
PARENTS.	10-NAME OF FATHER, Not known	
	11-BIRTHPLACE OF FATHER (State or Country),	
	12-MAIDEN NAME OF MOTHER	
	13-BIRTHPLACE OF MOTHER (State or Country),	

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Charles H. Kunkles*  
(Address) 623 Barrett Ave.

## 15-

MAR 28 1922

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 25, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from  
MAR 23 1922 191, to MAR 25 1922 191,  
that I saw him alive on MAR 23 1922 191,  
and that death occurred, on the date stated above, at 10<sup>15</sup> p m.  
The CAUSE OF DEATH\* was as follows:  
General Sepsis

(Duration) ... yrs. ... mos. ... ds.  
CONTRIBUTORY (Secondary) Pulmonary Tuberculosis  
(Duration) ... yrs. ... mos. ... ds.  
(Signed) *Dr. D. H. M. D.*  
MAR 27, 1922. (Address) *928 E. North*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

## 20-UNDERTAKER,

## ADDRESS

*Woodlawn*  
*E. A. Woodlawn**March 29, 1922*  
*501 E. 22*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62899

D 62899

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 915 Sarah Ann ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. 915 Sarah Ann ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

ds. How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY That I attended deceased from

Mar 23 1922 to Mar 26 1922

that I last saw h alive on Mar 26 1922

and that death occurred, on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH\* was as follows:

Apoplexy

CONTRIBUTOR (Secondary)

(duration)

yrs.

mos.

ds.

(Signed)

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 Address

\*State the Disease Causing Death or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 62900

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62900

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *414 S. Maderia* ST. *1* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *William F. Brown*(a) RESIDENCE. NO. *414 S. Maderia* ST. *1* WARD.  
(Usual place of abode) (If nonresident give city or town and State)Length of residence in city or town where death occurred *2* yrs. *5* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct. 5<sup>th</sup> 1919*7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*2* *5* *22*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto. Md.*  
(State or country)10 NAME OF FATHER *Francis J. H. Brown*11 BIRTHPLACE OF FATHER (city or town) *Balto. Md.*  
(State or country)12 MAIDEN NAME OF MOTHER *Bertie V. Olski*13 BIRTHPLACE OF MOTHER (city or town) *Balto. Md.*  
(State or country)14 Informant *Francis J. H. Brown*  
(Address) *414 S. Maderia St.*15 *MAR 28 1922* *GG* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 27<sup>th</sup> 1922*17 I HEREBY CERTIFY, That I attended deceased from *March 2*, 1922, to *March 26*, 1922,that I last saw him alive on *March 26*, 1922,and that death occurred, on the date stated above, at *4:01 a* m.

The CAUSE OF DEATH\* was as follows:

*Broncho-Pneumonia*  
*no contagious dis*(duration) yrs. *1* mos. ds.

CONTRIBUTORY (Secondary)

*Empyema*  
(duration) yrs. mos. *7* ds.18 Where was disease contracted if not at place of death? ☒Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Wound*(Signed) *Frank G. Brander*, M. D.19 (Address) *125 S. Maderia*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Holy Redeemer Church*

20 UNDERTAKER

*Lilly & Zeiler*

DATE OF BURIAL

*March 28<sup>th</sup> 1922*

ADDRESS

*400 S. Maderia St.*

Information should be carefully supplied. Age should be given in years, months, and days. Exact statement of occupation and cause of death in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62901

## CERTIFICATE OF DEATH.

162 D 62901

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital* ST.: *8th* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Betty Wolderman*(a) RESIDENCE. No. *1513 E. Preston St.* ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *OOD*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *3/27/22* 7 AGE Years Months Days If LESS than 1 day, 2 hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Hebrew Hospital* (State or country)10 NAME OF FATHER *Julius Wolderman*11 BIRTHPLACE OF FATHER (city or town) *Russia* (State or country)12 MAIDEN NAME OF MOTHER *Anna Greenfield*13 BIRTHPLACE OF MOTHER (city or town) *Russia* (State or country)14 Informant *J. Wolderman* (Address) *1513 E. Preston St.*15 Filled *19 MAR 28 1922*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/28/22* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *3/27*, 19 *22*, to *3/28*, 19 *22*, that I last saw him alive on *3/27*, 19 *22*, and that death occurred, on the date stated above, at *5:45 a. m.*

The CAUSE OF DEATH\* was as follows:

*Asphyxia*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date of *none*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Julius Stologan*, M. D.(Address) *Hebrew Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Hebrew Rosedale*

20 UNDERTAKER

*Mat Linton*

DATE OF BURIAL

*3/28, 1922*

ADDRESS

*1127 E. Balto St.*

Information should be carefully checked and corrected before filing. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 62902  
154736

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62902

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

## 2. FULL NAME

Moraline Bunchey

## (a) RESIDENCE NO.

2612 Jefferson St.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

1 yrs. 11 mos. 22 ds.

How long in U. S., if of foreign birth?

1 yrs. 11 mos. 22 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female WhiteSingle

5a If married, widowed, or divorced

NeverWm Bunchey (Father)

6 DATE OF BIRTH (month, day, and year)

March 30, 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

11128

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Wm Bunchey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Goldie Yaniger

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

JOHNS HOPKINS HOSPITALSec 2

15

Filed

MAR 28 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 28, 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 24, 1922, to March 28, 1922,  
that I last saw her alive on March 28, 1922,

and that death occurred, on the date stated above, at

8:30 A.M.

The CAUSE OF DEATH\* was as follows:

Pneumonia, lobar(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

2612 Jefferson StDid an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

T.B. Day

M. D.

(Address)

Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Hebrew Burial

20 UNDERTAKER

Max Linton

DATE OF BURIAL

3/28/22

ADDRESS

1127 E. Belts

mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.



D 62903

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62903

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Veterans' Hosp. #56

Fort McHenry Md.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

ST. WARD

2-FULL NAME Leonard O. Tucker

(a) RESIDENCE NO. US. Veterans' Hosp. #56

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

unknown

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

20 yrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Seaman

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

S/S City of Norfolk

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Virginia.

10 NAME OF FATHER

Clifford Tucker

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

unknown

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

unknown

14

Informant

E.T. Rosenbrock (Registrar)

(Address)

US.V. Hosp. #56 Md.

15

Filed

MAR 28 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 27, 1922

17

I HEREBY CERTIFY, That I attended deceased from  
March 22, 1922 March 27, 1922

that I last saw him alive on March 27, 1922,

and that death occurred, on the date stated above, at

10-10A.M.

The CAUSE OF DEATH\* was as follows:

Pneumonia lobar.

CONTRIBUTORY  
(Secondary)18 Where was disease contracted  
if not at place of death?

Unknown

Did an operation precede death?

No

Was there an autopsy?

No.

What test confirmed diagnosis?

Clinic report.

(Signed)

3/27/22

(Address)

US.V. Hosp. #56 Fort Mc.  
Henry Md.\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

DATE OF BURIAL

3/28 1922

ADDRESS

1127 E. Balt.

D 62904

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62904

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2803 Eastern ay ST., 1 WARD)2. FULL NAME James E. Humphreys(a) RESIDENCE NO. 2803 Eastern ay ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Annie M. Gurns

6 DATE OF BIRTH (month, day, and year)

Apr. 9, 1866

7 AGE

55

Years

Months

6

Days

27

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Machinist 078

(b) General nature of industry, business, or establishment in which employed (or employer)

W. E. R. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto.

10 NAME OF FATHER

Edgar J. Humphreys

11 BIRTHPLACE OF FATHER (city or town) (State or country)

England

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Not known

14

Informant (Address)

Annie M. Humphreys 2803 Eastern ay

15

MAR 28 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1922

17

I HEREBY CERTIFY, That I attended deceased from

27 Dec 1921, to 25 Mar 1922.that I last saw him alive on 25 Mar 1922.and that death occurred, on the date stated above, at 5 A. M.

The CAUSE OF DEATH\* was as follows:

Angina pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Autopsy(Signed) W. E. R. Co., M. D., 19 (Address) 3015 Ellwood

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park

DATE OF BURIAL

3/29 1922

20 UNDERTAKER

E. J. Fanning 1460 Rutty

ADDRESS

D 62905

## HEALTH DEPARTMENT—CITY OF BALTIMORE, D 62905

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1010 N. Strickes* ST *16* WARD)2-FULL NAME *Herbert Parnell*(a) RESIDENCE. NO. *1010 N. Strickes* ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*white*

5 Single, Married, Widowed, or Divorced (write the word)

*single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug. 28-1921*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15 Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 25-1922*17 I HEREBY CERTIFY, That I attended deceased from *Mar. 10* 1922, to *Mar. 24* 1922,that I last saw him alive on *Mar. 24* 1922,and that death occurred, on the date stated above, at *7:00 A. M.*

The CAUSE OF DEATH\* was as follows:

*Broncho-pneumonia*(duration) — yrs. — mos. *13* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *none*

(Signed)

19 (Address) *906 N. Strickes St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior*



D 62906

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Sq. Hoop. ST.* 16 WARD)

## 2-FULL NAME

*Mrs. Katie Potter*

## (a) RESIDENCE NO.

*1119 N. Gilmore* ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

*2 1/2 yrs.* mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Female white Widow*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*unknown*

## 6 DATE OF BIRTH (month, day, and year)

*? ? 1872*

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*50*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

*ood*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Annapolis, Md.*

## 10 NAME OF FATHER

*Thos. Jones*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Md.*

## 12 MAIDEN NAME OF MOTHER

*Unknown*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Md.*

## 14

Informant  
(Address)*Mrs. Helen Bruner  
1119 N. Gilmore St*

## 15

Filed

*MAR 28 1922**J. H. Helm* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/27/* 19 *22*

17 I HEREBY CERTIFY, That I attended deceased from

*Mar - 18*, 1922, to *Mar - 27*, 1922.that I last saw *her* alive on *Mar - 27*, 1922.and that death occurred, on the date stated above, at *2:45* p. m.

The CAUSE OF DEATH\* was as follows:

*Intestinal Obstruction*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
If not at place of death?Did an operation precede death? *yes* Date of *3/24/22*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Newton S. Park*, M. D.*3/27, 1922* (Address) *Franklin Sq. Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*Loudon Park**3/29/* 19 *22*  
ADDRESS

20 UNDERTAKER

*Mr. Cook, 502 E. North Ave*

Exact statement of cause of death should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 62907

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 62907

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bay View Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME

William H. Johnson

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

Unknown

ST. WARD.

WARD.

(If nonresident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

Divorced (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1850

7 AGE

72

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Clerk

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Do

12 MAIDEN NAME OF MOTHER

Do

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)Bay View Hospital  
Dr. Johnson

15

Filed

Robert E. Hartman

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 24, 1922

17 I HEREBY CERTIFY, That I attended deceased from  
July 23, 1887, to March 24, 1922  
that I last saw him alive on March 23, 1922.and that death occurred, on the date stated above, at 2:00 p.m.  
The CAUSE OF DEATH\* was as follows:

Acute Myocardial Insufficiency

CONTRIBUTORY  
(Secondary)(duration) yrs. mos. ds.  
Arterio Sclerosis18 Where was disease contracted  
if not at place of death?(duration) yrs. mos. ds.  
Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

3/25/22

H. H. Johnson, M. D.  
Bay View Hospital\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

Health.

ADDRESS

MAR 28 1922

Information should be carefully supplied, so that it may be properly classified. See instructions on back of certificates.

2281922

Burial Permit Clerk

D 62908

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62908

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *69 Bellevue Ave.* ST., WARD *179*)

## 2-FULL NAME

(a) RESIDENCE NO. *69 Bellevue Ave.* ST., WARD *179*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White**Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of*William H. Wilson*

6 DATE OF BIRTH (month, day, and year)

*March 31 1857*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*70**11**28*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

*at home*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Balto Maryland*

10 NAME OF FATHER

*Daniel Steever*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Balto Maryland*

12 MAIDEN NAME OF MOTHER

*Ann Broome*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Balto Maryland*

14

Informant  
(Address)*Wm H. Wilson*

15

*Robert F. Harrison,*

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 27 1922*17 I HEREBY CERTIFY, That I attended deceased from  
*March 17, 1922* to *March 27, 1922*that I last saw *her* alive on *11 26 1922*and that death occurred, on the date stated above, at *5:30 a. m.*

The CAUSE OF DEATH\* was as follows:

*Bronchial Pneumonia*CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.  
*Chron. In. Nephritis*18 Where was disease contracted  
if not at place of death? *at home*Did an operation precede death? *no* Date of *—*Was there an autopsy? *yes*  
What test confirmed diagnosis? *Physical Signs*(Signed) *C. S. Keer* M. D.(Address) *408 S. PATOK Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL*Int. Carmel Cemetery*

20 UNDERTAKER

*Fred. L. Lacombe*

DATE OF BURIAL

ADDRESS

*March 27 1922**Fullerton*

Exact statement of cause of death should be carefully supplied. See instructions on back of certificates.

82 &amp; 1322

D 62909

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

Registered No. C

## 1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital. St. 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Simon Kuzawski.

(Residence in Baltimore: No. 3 Cypress St. Curtis Bay. St.; yrs. 3 mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, (Write the word.) Single.

6-DATE OF BIRTH, Do not know. 1. (Month) (Day) (Year)

7-AGE, 30 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Car fitter. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Poland.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER, (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Truckiewicz.

(Address) 11 Filbert St Curtis Bay.

15-

Robert P. Harrison,

192

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 24th. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry &amp; autopsy thereon and from the evidence obtained by said inquiry &amp; autopsy find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Congestion of the Lungs &amp; Rupture of the Liver. Accidentally caught between two steel plates.

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Signed) M. D. (Coroner) M. D. (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

South Balto. Car &amp; Foundry Co. March 15th. 1922.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Holy Cross 3/29 1922

20-UNDERAKER, ADDRESS

Wm. F. Harrison, 116 E. Oak

B- Every item of information should be stated in plain terms, so that it may be properly classified. Cause of Death is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62910

## CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE, NO.

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. 8 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of

Mrs Florence Galloway

6 DATE OF BIRTH (month, day, and year)

July 15<sup>th</sup> 1888

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

33 years

8

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Correspondent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

John Galloway

11 BIRTHPLACE OF FATHER (city or town)

Baltimore

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary Stein

13 BIRTHPLACE OF MOTHER (city or town)

Baltimore

(State or country)

Maryland

14

Informant (Address)

J Elmer Galloway  
2923 Ridgewood Ave

15

Filed

Robert F. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28, 1922

17

I HEREBY CERTIFY, That I attended deceased from

February 2, 1922, to March 28, 1922,

that I last saw him alive on March 28, 1922,

and that death occurred, on the date stated above, at 7:20 A. M.

The CAUSE OF DEATH\* was as follows:

Myocardial infarction

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

Thyrototoxicosis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of March 27-1922

Was there an autopsy?

What test confirmed diagnosis?

Clinical findings

(Signed)

8/4, 1922

(Address)

Camp Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cem

Mar 31 1922

20 UNDERTAKER

Capt B. Cook

1003 N. Baltimore

This certificate should be carefully filled out, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

AR 28 1922

## HEALTH DEPARTMENT--CITY OF BALTIMORE

D 62911

## CERTIFICATE OF DEATH

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

828 1/2 Franklin Road ST. 16

WARD)

2-FULL NAME

Ernest Harrison Abraham

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

828 1/2 Franklin Road

St.

Life

yrs.

mos.

ds.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE white 5-SINGLE MARKED WIDOWED OR DIVORCED (Write the word) Single

6-DATE OF BIRTH May 18 1921 (Month) (Day) (Year)

7-AGE 10 mos. 13 ds. or min. 1 day, hrs. If LESS than 1 day, hrs., min.?

8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Unemployed

9-BIRTHPLACE (State or country) Balt. Md.

10-NAME OF FATHER Arthur Abraham

11-BIRTHPLACE OF FATHER (State or country) Balt. Md.

12-MAIDEN NAME OF MOTHER Augusta Harris

13-BIRTHPLACE OF MOTHER (State or country) Balt. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Augusta Abraham

(Address) 828 1/2 Franklin St.

15-

Robert P. Harrison,

191

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH March 27 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 18 1922 to Mar. 28 1922, that I saw him alive on Mar. 27 1922, and that death occurred, on the date stated above, at 11:00 m. The CAUSE OF DEATH\* was as follows:

Capillary Bronchitis (Duration) yrs. mos. ds. 10

Contributory (SECONDARY) Emphysema (Duration) yrs. mos. ds. 1 hour

(Signed) Robert P. Harrison M. D. Mar. 28 1922 [Address] 1318 S. Charles St.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted. If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Landon Park Cem.

DATE OF BURIAL

Mar. 30 1922

20-UNDERTAKER

Joseph B. Cook

ADDRESS

1003 1/2 Balt. St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62912

## CERTIFICATE OF DEATH.

31 D 62912

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *404 S. Highland* ST., *76* WARD)

## 2-FULL NAME

*Frances M. Stohenstein*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

*404 S. Highland Ave., ST., 76 WARD*

(Usual place of abode)

Length of residence in city or town where death occurred *3* yrs. *3* mos. *3* ds.

How long in U. S. If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*Nov 19 - 1900*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*21**4**7*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

*at home*

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Baltimore Co Md.*

## 10 NAME OF FATHER

*Frederick Stohenstein*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Pa.*

## 12 MAIDEN NAME OF MOTHER

*May L. Ellbach*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*

## 14

Informant

(Address)

*Frederick Stohenstein  
404 S. Highland Ave.*

## 15

Filed

*Robert P. Harrison*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 26 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan 10th 1922* to *March 26th 1922*that I last saw him alive on *March 25th 1922*and that death occurred, on the date stated above, at *7:20 P. m.*

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis*(duration) yrs. *3* mos. *3* ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. *1* mos. *3* ds.

18 Where was disease contracted if not at place of death?

Date of

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*W. O. Storer* M. D.

(Address)

*1511 E. Pratt St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

*March 29 1922*

## 20 UNDERTAKER

ADDRESS

*403 Wolfe**Lilly & Giller*

28 1922

D 62913

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62913

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No

2195 Ann

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Constance Chaillie

## (a) RESIDENCE. NO.

(Usual place of abode)

2195 Ann

ST.:

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

0

yrs.

I

mos.

8

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female,

4 COLOR OR RACE

White,

5 Single, Married, Widowed, or Divorced (write the word)

Single,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby., 20/22.

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

0

I

8

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

None,

9 BIRTHPLACE (city or town) (State or country)

Baltimore,

Md.,

10 NAME OF FATHER Albert Chaillie,

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Missouri,

12 MAIDEN NAME OF MOTHER Anna Belkowska,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore, Md.

14

Informant (Address)

Mrs. Mary Chaillie,  
# 219 So. Ann Street

15

Filed

1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28- 19 22.

17

I HEREBY CERTIFY, That I attended deceased from

Mar 27- 19 22, to Mar 28- 19 22,

that I last saw him alive on Mar 27- 19 22,

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH\* was as follows:

Meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Mar 28 1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Cross Cemetery

MAR 29. 19 22

20 UNDERTAKER

ADDRESS

M. F. Sadowski

7.5 S. Ann St.

This certificate should be carefully examined, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

R 28 1922

Burial Permit Clerk



D 62914

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 324 S. Wolfe St. ST. V WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 324 S. Wolfe St. St. 17 yrs. 2 mos. 11 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)Married

6-DATE OF BIRTH

Jan 16, 1905  
(Month) (Day) (Year)

7-AGE

17 yrs. 2 mos. 11 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

House wif  
037

9-BIRTHPLACE

(State or Country)

Bay. St. Louis Miss

10-NAME OF FATHER

Andrew Wiesniewski

11-BIRTHPLACE OF FATHER

(State or Country)

Poland

12-MAIDEN NAME OF MOTHER

Katlon Zielinski

13-BIRTHPLACE OF MOTHER

(State or Country)

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Katlon Zielinski

(Address)

324 S. Wolfe St.

15-

Filed

Robert J. Bartlett

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

March 27, 1922  
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from Mar 10 1912, to Mar 27 1922,that I saw him alive on Mar 27 1912.and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH was as follows:

Solar Pneumonia(Duration) 17 yrs. 2 mos. 11 ds.

CONTRIBUTORY (Secondary)

(Duration) 17 yrs. 2 mos. 11 ds.(Signed) William O. Pearson M. D.Mar 28, 1922 (Address) 805 N. Avenue

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 17 yrs. 2 mos. 11 ds. In the State 17 yrs. 2 mos. 11 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Stanislaus

DATE OF BURIAL

March 30, 1922

20-UNDERTAKER

M. J. Sadowski

ADDRESS

705 S. Avenue

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

AR 2 81922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62915

## CERTIFICATE OF DEATH.

179. D 62915

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1115 Emsor St ST. 10 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME James A. Hamlin(a) RESIDENCE NO. 1115 Emsor St ST. 10 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Carrie A. Hamlin6 DATE OF BIRTH (month, day, and year) Jan 18 - 18527 AGE Years 70 Months 2 Days 075 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ind  
(State or country)10 NAME OF FATHER Thomas S. Hamlin

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ind12 MAIDEN NAME OF MOTHER Ann Crandall

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ind14 Informant Mrs Carrie A. Hamlin  
(Address) 1115 Emsor St15 Robert P. Harrison

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22 192217 I HEREBY CERTIFY, That I attended deceased from Jan 13 1922 to Mar 22 1922  
that I last saw him alive on Mar 22 1922and that death occurred, on the date stated above, at 10:57 m.

The CAUSE OF DEATH\* was as follows:

Chronic Bronchitis  
Myocarditis - and  
uraemia.

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Microscopic(Signed) Charles J. ... M. D.Address 4706 ...

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Parkwood Cem. Mar 29 1922

20 UNDERTAKER

ADDRESS

Wm Cook. 502 E. ...

AR 28 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62916

D 62916

## CERTIFICATE OF DEATH.

REGISTERED NO.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 South ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO. 108 South ST.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth

WARD

(If non-resident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Mar. 1, 1922, to Mar. 28, 1922.

that I last saw him alive on Mar. 27, 1922.

and that death occurred, on the date stated above, at 325 G.

The CAUSE OF DEATH\* was as follows:

Valvular Heart Disease. (Aortic Stenosis.) (duration) yrs. mos. 27 ds.

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical Exam. (Signed) J. H. V. M. D.

3/28/22 (Address) 558 W. Lombard St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 81939

19

Registrar

Dr. Porter 800 Clark St. Lombard

William Lach 5026 North Ave

D 62917

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 62917

## CERTIFICATE OF DEATH.

31

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 433 - East 23 ST. 12 WARD)

## 2-FULL NAME

(a) RESIDENCE No. 433 - East 23 ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Elyza Penell

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE Years 54 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Elyza Penell (Address) 433 - East 23 St

15 MAR 29 1922 ROBERT N. KRAUTER, Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 2, 1922, to Mar 26, 1922, that I last saw him alive on Mar 26, 1922, and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) 24 hrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam -

(Signed) P. G. Garbutt M. D.

Mar 18, 1922 (Address) 1534 - 1st St. Hill Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Tabernacle Cem Mar 29 1922

20 UNDERTAKER Harford Co. Md. ADDRESS 378

Samuel Newsley

Information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62918

## CERTIFICATE OF DEATH.

161 D 62918

## 1. PLACE OF DEATH

CITY OF BALTIMORE (NO.

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ST. WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14

Informant

(Address)

15

File

MAR 29 1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

March 27, 1922, to March 28, 1922

that I last saw him alive on March 28, 1922

and that death occurred, on the date stated above, at 3:04 a.m.

The CAUSE OF DEATH was as follows:

Premature infant  
about 7 months of age  
Respiratory failure  
(duration 3 hours) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. W. Scott, M. D.

19 (Address) St. Agnes Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-NOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62919

## CERTIFICATE OF DEATH.

D 62919

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 425 S. Smallwood ST., 20 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Marie Dunkerly

## (a) RESIDENCE NO.

425 S. Smallwood St.

## WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. 7 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) July 31 1909

## 7 AGE

12

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

BaltimoreMd.10 NAME OF FATHER Louis Dunkerly

11 BIRTHPLACE OF FATHER (city or town)

Baltimore

(State or country)

Md.12 MAIDEN NAME OF MOTHER Lena Hoffman

13 BIRTHPLACE OF MOTHER (city or town)

Baltimore

(State or country)

Md.

## 14

Informant  
(Address)Mrs. Lena Norton425 S. Smallwood St.

## 15

MAR 29 1922ROBERT R. KRAUTER

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 28 19 22

## 17

I HEREBY CERTIFY, That I attended deceased from March 19 1922 to March 28 19 22, that I last saw her alive on March 28 19 22, and that death occurred, on the date stated above, at 2 A. M.

The CAUSE OF DEATH\* was as follows:

Marler Bronchopneumonia  
Acute Endocarditis

## CONTRIBUTORY (Secondary)

Pulmonary Edema  
(duration) yrs. mos. ds.  
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herbert C. Metch M. D.Mar. 28 19 22 (Address) 151 Thelma Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## 20 UNDERTAKER

New Catholic Cem  
Joseph B. Cook

## DATE OF BURIAL

## ADDRESS

Mar 30 19 22103 N. Falls St

62920

## D 62920

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1608 W. Lombard St., ST., WARD

(a) RESIDENCE NO. \_\_\_\_\_ ST. \_\_\_\_\_ WARD \_\_\_\_\_  
(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred 1 1 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 27 19 22

17 I HEREBY CERTIFY That I attended deceased from  
Jan 1, 1922, to Feb 27, 1922  
that I last saw her alive on Feb 27, 1922

and that death occurred, on the date stated above, at 5:15 a.m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Liver

(duration) ..... yrs. .... mos. .... da.

**CONTRIBUTORY**  
(Secondary)

(duration) .....yrs. ....mos. ....ds.

18 Where was disease contracted  
if not at place of death?.....

Did an operation precede death? no Date of.

Was there an autopsy? .... no

What test confirmed diagnosis? *Typhoid fever*

(Signed) Walter Alex M. D.

Feb. 23, 1922 (Address) 341 Fulton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL	DATE OF BURIAL
---	----------------

Greenmount Club May 29 1942

TO UNDERTAKER  
Joseph B. Cook  
ADDRESS  
1003 N. Balto  
St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62921

62921

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 823 Powers St. ST., 13 WARD)2-FULL NAME Anna T. Abbott(a) RESIDENCE NO. 823 Powers St. ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. 3 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of Albert T. Abbott (or) WIFE of6 DATE OF BIRTH (month, day, and year) Nov. 28-18967 AGE Years 25 Months 3 Days 27 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland10 NAME OF FATHER John D. Harding11 BIRTHPLACE OF FATHER (city or town) Howard Co. (State or country) Maryland12 MAIDEN NAME OF MOTHER Mary C. Harrah13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14

Informant Albert T. Abbott (Address) 823 Powers St.

15

MAR 29 1922

ROBERT R. KEAT

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 192217 I HEREBY CERTIFY, That I attended deceased from March 12, 1922, to March 27, 1922, that I last saw her alive on March 27, 1922, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH\* was as follows:

Coalescing broncho  
pneumonia & 7 1/2 month  
premature birth as a complication  
(duration) yrs. mos. 14 ds.CONTRIBUTORY (Secondary) Pulmonary edema  
(duration) yrs. mos. 1 ds.18 Where was disease contracted if not at place of death? yesDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Examination.(Signed) W. H. Smith, M. D.3/28, 1922 (Address) 3429 Chestnut Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Greenmount (Carroll Co)

DATE OF BURIAL

20 UNDERTAKER Horace F. Burge

ADDRESS

3631 Falls Rd.

N. B.—Information should be carefully supplied. AGE should be in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62922

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3627 Elm Ave. ST. 13 WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 3627 Elm Ave. ST. 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. 2 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.REGISTERED NO. D 62922

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 31-19127 AGE Years 9 Months 2 Days 27 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

## 14

Informant (Address) Jesse R. Burrier 3627 Elm Ave.

## 15

Burial Permit Clark Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 192217 I HEREBY CERTIFY, That I attended deceased from March 16, 1922, to March 27, 1922.that I last saw him alive on March 26, 1922and that death occurred, on the date stated above, at 7<sup>10</sup> A. m.

The CAUSE OF DEATH\* was as follows:

Chorea  
(duration) yrs. mos. ds. Approximately 2

CONTRIBUTORY (Secondary)

Chronic Pneumonia  
(duration) yrs. mos. ds. 6

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -Was there an autopsy? NoWhat test confirmed diagnosis? Physical Exams(Signed) R. B. Norvick M. D.24, 1922 (Address) 3547 Chestnut Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

St. Mary's Hampden

FUNERTAKER

Horace H. Burgee363 Falls Rd.

## DATE OF BURIAL

March 29 1922

ADDRESS

363 Falls Rd.

N. B.—WRITER'S ATTENTION should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

MAR 29 1922

D 62923

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62923

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2418 Egan Place*)ST. *7<sup>th</sup>* WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Leonore Smith*(Residence in Baltimore: No. *2418 Egan Place*)St. *7<sup>th</sup>* yrs. *5* mos. *22* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Female*

4-COLOR OR RACE,

*white*5-~~SINGLE~~~~MARRIED~~~~WIDOWED~~~~OR DIVORCED~~

(Write the word.)

*Married*

6-DATE OF BIRTH,

*febr. 5, 1864.*  
(Month) (Day) (Year)7-AGE, *58**58 yrs. 11 mos. 22 ds.*

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Lawyer*9-BIRTHPLACE,  
(State or Country),*Balto.*

10-NAME OF FATHER,

*J. G. Hoffmann*11-BIRTHPLACE OF FATHER  
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*unknown*13-BIRTHPLACE OF MOTHER  
(State or Country),*unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Henry Smith, Suburban*(Address) *2418 Egan Place*

15-

Filed *MAR 29 1922*

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*March 28, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Jan. 1, 1920, to March 27, 1922,*that I saw her alive on *March 27, 1922,*and that death occurred, on the date stated above, at *2:14* m.

The CAUSE OF DEATH\* was as follows:

*Acute Indigestion*(Duration) *5* yrs. *1* mos. *1* ds.CONTRIBUTORY  
(Secondary)*Interstitial Nephritis*(Duration) *2* yrs. *2* mos. *2* ds.

(Signed)

*March 28, 1922* (Address) *1001 S. 10th St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *5* yrs. *1* mos. *1* ds. In the State *1* yrs. *1* mos. *1* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

*St. Mary's Cemetery*

DATE OF BURIAL.

*Mar. 30, 1922*

20-UNDERTAKER

*Robt. J. Turner*

ADDRESS

*1001 S. 10th St.*

N.B.—Every item of information should be carefully checked, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

D 62924 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62924

## CERTIFICATE OF DEATH

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1911 E Chase ST.)

WARD 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. 1911 E Chase ST.

WARD.

(If nonresident, give city or town and State)

(Usual place of abode)  
Length of residence in city or town where death occurred 29 yrs. mos. ds.

How long in U. S., if of foreign birth? 29 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Married

If married, widowed or divorced  
HUSBAND of (or WIFE of)

Margaret Rambo

DATE OF BIRTH (month, day, and year)

AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

68

1

15

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

MAR 23 1922

J. W. Wehm.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

I HEREBY CERTIFY, That I attended deceased from Mar 17, 1922, to Mar 27, 1922, that I last saw him alive on Mar 26, 1922, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Pneumonia

(duration)

yrs.

mos.

20 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Address

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

N. Broadway

Baltimore Cemetery

March 29, 1922

Address 1203





REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*History of origin  
vague. Cause  
unknown*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62926

## CERTIFICATE OF DEATH.

179 D 62926

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1415 N. Lafayette Ave* ST. *16* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Emma J. Reddish*(a) RESIDENCE NO. *928 N. Carrollton Ave* ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *68* yrs. *4* mos. *26* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND OF  
(or) WIFE of*Charles H. Reddish*6 DATE OF BIRTH (month, day, and year) *Nov. 2 1853*7 AGE Years *68* Months *4* Days *26* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*037*

(b) General nature of industry, business, or establishment in which employed (or employer)

*House-wife*

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto. Ind*  
(State or country)10 NAME OF FATHER *Thomas H. Mc Gee*11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Ireland*12 MAIDEN NAME OF MOTHER *Eliza Ellen Bishop*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Ind*14 Informant *Charles H. Reddish*  
(Address) *928 N. Carrollton Ave*15 *MAR 29 1922* ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 28 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan 10 1922* to *Mar 28 1922*, that I last saw her alive on *Mar 28 1922*, and that death occurred, on the date stated above, at *1:30 p.m.*

The CAUSE OF DEATH was as follows:

*Interstitial Nephritis*CONTRIBUTORY (Secondary) *Apoplexy* Duration yrs. *3* mos. ds. *9 hours*

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date of \_\_\_\_\_Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Colin Murray* M. D.(Address) *1241 N. Lafayette Ave*

State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Lorraine Park Cemetery*

DATE OF BURIAL

*Mar 30, 22*

20 UNDERTAKER

*John F. Denny*

ADDRESS

*715 Light*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62927

D 62927

## CERTIFICATE OF DEATH.

180-001

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2433 Jefferson ST. 6 WARD)

2. FULL NAME *Caroline Walters*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 2433 Jefferson ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? 66 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*5a If married, widowed, or divorced  
HUSBAND of *Wm. Walters*  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Dec. 1st 1859*7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*62 3 26*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Steakhouse*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Schlöss Bros.*9 BIRTHPLACE (city or town) *Washington*  
(State or country) *D.C.*10 NAME OF FATHER *Geo. Spence*11 BIRTHPLACE OF FATHER (city or town) *Wash.*  
(State or country) *D.C.*12 MAIDEN NAME OF MOTHER *Antonia*13 BIRTHPLACE OF MOTHER (city or town) *Wash.*  
(State or country) *D.C.*14 Informant *Mary Spence*  
(Address) *2433 Jefferson St.*15 *MAR 9 1922* ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 27th 1922*17 I HEREBY CERTIFY, That I attended deceased from *March 8, 1922*, to *March 27, 1922*, that I last saw her alive on *March 27, 1922*, and that death occurred, on the date stated above, at *1:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Bronchitis - Pneumonia*CONTRIBUTORY *Exhaustion*  
(Secondary) (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Examination of*  
(Signed) *Adolph C. Eisenberg* M. D.1922 (Address) *2201-203 Orleans St.*

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Greenwood Park Burial* *Mar. 30 1922*

UNDERTAKER

ADDRESS *2016**Philip H. Hennig* *Orleans St.*

mation should be carefully supplied. Exact statement of occupation should be given in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62928

## CERTIFICATE OF DEATH.

179  
20  
REGISTERED NO. 62928

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3532 Frederick Ave. ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME J. Henry Heise

(Residence in Baltimore: No. 3532 Frederick Ave. St.; 67 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

Widowed

6-DATE OF BIRTH,

April 19<sup>th</sup>, 1842  
(Month) (Day) (Year)

7-AGE,

79 yrs., 11 mos., 7 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Retired Bay  
Buffg. 0869-BIRTHPLACE,  
(State or Country).

Germany.

10-NAME OF FATHER,

not known

11-BIRTHPLACE OF FATHER  
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

not known

13-BIRTHPLACE OF MOTHER  
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Chas E H Heise (Son)

(Address)

Tren Hills City

15-

Filed MAR 29 1922 ROBERT R. KRAUTER,

Registrar.  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 25, 1922, 191...  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Mar. 11-22, 191... to Mar. 26, 191...

that I saw him alive on Mar. 26, 191...

and that death occurred, on the date stated above, at 5-50 p.m.

The CAUSE OF DEATH\* was as follows:

Apoplexy

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY  
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191... (Address).....

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

St Pauls Violentville

DATE OF BURIAL,

3-29, 1922

20-UNDERTAKER

Mrs Chas A G Rhode

ADDRESS

Arlington Ave

N.B.—Every item of information should be given in plain terms, so that it may be properly understood. CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.



N. B.—Every item of information should be carefully supplied. AGE must be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62929

CERTIFICATE OF DEATH.

D 62929

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *16* ST. *16* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1624 Harlem Ave.*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, ....hrs. or ....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE (State or Country).

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MAR 29 1922

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

(Duration) yrs. mos. ds.

(Duration) yrs. mos. ds.

(Coroner.)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

D 62930 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62930

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 644 S. Curley. ST., 1 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

John George Horcher

## (a) RESIDENCE

No. 644 S. Curley.

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Life

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Bertha Horcher

6 DATE OF BIRTH (month, day, and year)

Jun 30, 1859

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

63

2

27

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

U.S. Light House

(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer. 040

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Baltimore Md.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Anna Jely

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Germany

14

Informant  
(Address)Bertha Horcher  
644 S. Curley St.

15

MAR 29 1922

ROBERT R. KRAUTER,

Official Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 27 1922

17

I HEREBY CERTIFY, That I attended deceased from  
March 25<sup>th</sup>, 1922, to March 27<sup>th</sup>, 1922.that I last saw him alive on March 27<sup>th</sup>, 1922.and that death occurred, on the date stated above, at 12<sup>00</sup> P.m.

The CAUSE OF DEATH was as follows:

Oedematous Laryngitis

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

Kutis Skrons

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Vernon J. Greening

M. D.

1922 (Address)

1900 Eastern Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Oak Lawn Cemetery

Mar 30 1922

20 UNDERTAKER

H. Sanders &amp; Sons

1710 Fleet St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62931

## CERTIFICATE OF DEATH.

173 D 62931

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 3 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Stevens(a) RESIDENCE. No. 1530 Fleet St.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Married</u>
------------------------	---------------------------------	--

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 1861

7 AGE <u>60</u>	Years	Months	Days	If LESS than 1 day, hrs. or min.
		--	--	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) Germany10 NAME OF FATHER John Ortcut11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Germany12 MAIDEN NAME OF MOTHER Mary Stepansky13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Germany14 Informant Hospital Records,  
(Address) Municipal Hospital.15 Filed 19 ROBERT H. KRAUTER,  
Registrar

MAR 29 1922

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 192217 I HEREBY CERTIFY, That I attended deceased from  
February 13 1922, to March 27 1922.that I last saw her alive on March 26 1922.and that death occurred, on the date stated above, at 5:10 A.M.

THE CAUSE OF DEATH\* was as follows:

Cholelithiasis

(duration) yrs. mos. ds.

CONTRIBUTORY Cudwings angina  
(Secondary) Bronchopneumonia (duration) yrs. mos. ds. 518 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. McNeill M. D.3/28/22 Address Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

First Evangelical CemeteryApril 30 1922

20 UNDERTAKER

ADDRESS

H. Sander & Sons1700 Fleet St.

mation should be carefully supplied. Also show CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

D 62932 HEALTH DEPARTMENT—CITY OF BALTIMORE 62932

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 S Castle ST.;

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ada M. Parks(Residence in Baltimore: No. 205 S Castle St.St.: 30 yrs., 0 mos., 0 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE,

White

## 5-SINGLE,

Married  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

Jan 2, 1860  
(Month) (Day) (Year)

## 7-AGE,

62 yrs., 2 mos., 0 ds.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...H. H.0379-BIRTHPLACE,  
(State or Country),N. Y.

## 10-NAME OF FATHER,

don't know11-BIRTHPLACE OF FATHER  
(State or Country),N. Y.

## 12-MAIDEN NAME OF MOTHER

don't know13-BIRTHPLACE OF MOTHER  
(State or Country),don't know

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barroso Parks(Address) 205 S. Castle St.

## 15-

Filed

191

MAR 28 1922

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

March 27, 1922  
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from March 11, 1922, to March 27, 1922,that I saw her alive on March 27, 1922,and that death occurred, on the date stated above, at 00 m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage(Duration) 17 yrs., 0 mos., 0 ds.CONTRIBUTORY  
(Secondary)(Duration) 0 yrs., 0 mos., 0 ds.(Signed) J. H. Heller M. D.3/29/1922 (Address) 1937 Gough St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs., 0 mos., 0 ds. In the State 0 yrs., 0 mos., 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Trinity Cemetery

## DATE OF BURIAL,

3-29-1922

## 20-UNDERTAKER

J. G. Moran

## ADDRESS

300 E. Baltimore



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

D 62833 PLACE OF DEATH

REGISTERED NO. 62833

CITY OF BALTIMORE (No. 2409 Baker St.

ST. 15 WARD

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Max Sacks.

(Residence in Baltimore: No. 2409 Baker St.

St.: 1 yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX male. 4-COLOR OR RACE white. 5-SINGLE, MARRIED, WIDOWED OR DIVORCED married (Write the word)

6-DATE OF BIRTH March 1, 1852 (Month) (Day) (Year)

7-AGE 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work retired teacher. (b) General nature of industry, business, or establishment in which employed (or employer) 045

9-BIRTHPLACE (State or country) Rumania

10-NAME OF FATHER Elijah Sacks

11-BIRTHPLACE OF FATHER (State or country) Rumania

12-MAIDEN NAME OF MOTHER Lizzie Sacks

13-BIRTHPLACE OF MOTHER (State or country) Rumania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. A. Sacks

(Address) 2409 Baker St.

15

File MAR 29 1922

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH March 28, 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to March 28, 1922, that I saw him alive on March 28, 1922, and that death occurred, on the date stated above, at 8 4, m. The CAUSE OF DEATH\* was as follows: Chronic Myocarditis

(Duration) 2 yrs. mos. ds.

Contributory Arteriosclerosis (SECONDARY) (Duration) 5 yrs. mos. ds.

(Signed) Louis J. Macht M. D.

March 28, 1922. (Address) 3420 Annapolis Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Rehman Nursing Home 3/29/22, 191

20-UNDERTAKER

Jack Lewis 1439 E. Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE D 62934

129

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. Net Hope Retreat ST. 28 WARD. (18 no)

(a) RESIDENCE. NO. Not known ST. 2 WARD. 1  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth: Not known mos. 0 ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1972

17 I HEREBY CERTIFY, That I attended deceased from  
 Mich 26<sup>th</sup> 1921, to March 22, 1922

that I last saw him alive on March 22, 1944

and that death occurred, on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Staphyritis

abs (duration) 1 yrs. 6 mos. 0 ds

CONTRIBUTORY (Secondary) *Dementia Senile*  
(duration) *4 yrs. 6 mos. 0 d.*

18 Where was disease contracted  
if not at place of death?..... *Baltimore Md*

Did an operation precede death? *No* Date of

Was there an autopsy?..... *No*

What test confirmed diagnosis?

(Signed) Frank J. Flannery M. D.  
19 1940 (Address) Put Hope Retreat

\*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
---	----------------

St Petersburg Mar 30 19

2. UNDERTAKER	ADDRESS
<i>John J. Falds</i>	<i>1200 W. Lombard</i>

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62935

## CERTIFICATE OF DEATH.

90D 62935

## 1-PLACE OF DEATH

CITY OF BALTIMORE

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No.

St.

yrs.,

mos.

ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,  
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Filed

191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from  
Jan 10 1922 to Mar. 27 1922  
that I saw her alive on Mar. 27 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)

(Signed)

Mar. 28, 1922

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N. B.—Every item or information on this certificate is important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62936

P 62936

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. <sup>N</sup>1211 Patterson Park ST., <sup>Ar</sup> WARD)

## 2-FULL NAME

William V. Sauner

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1211 N. Patterson Park ST., <sup>Ar</sup> WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary F. Sauner

6 DATE OF BIRTH (month, day, and year) Feb 14 1869

7 AGE Years 53 Months 1 Days 27 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

W. F. Sauner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto.

12 MAIDEN NAME OF MOTHER

Virginia Huzzo

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant (Address)

Mary F. Sauner 1211 N. Patterson Park ST.

15

Filed

MAR 29 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1922, to March 27, 1922, that I last saw him alive on March 27, 1922, and that death occurred, on the date stated above, at 12<sup>00</sup> m. The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs (Signed) Albert L. Hesser M. D.

1621 N. Lafayette Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

Geo M. Frickson

DATE OF BURIAL

Mar 30 1922

ADDRESS

811 N. W. Ave

N. B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated. Exact statement of OCCASION OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

117 62937

D 62937  
1-PLACE OF DEATH Union Memorial Hospital  
154 Division StreetREGISTERED NO.  
(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

CITY OF BALTIMORE: (No.)

2-FULL NAME Mr. Alvin N. Bastable

(a) RESIDENCE NO. 2225 St. Paul St. ST. 17 WARD (If nonresident give city or town and State)  
Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced  
HUSBAND of Mrs. Alvin N. Bastable  
(or) WIFE6 DATE OF BIRTH (month, day, and year) 1836-11-24  
7 AGE Years 85 Months 5 Days 14 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

10 NAME OF FATHER Moxley Bastable

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Eliza Davidson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Hiram G. Bastable  
(Address) 2225 St. Paul St.

15 MAR 29 1922

ROBERT A. KRAUTER,  
Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1922

17 I HEREBY CERTIFY, That I attended deceased from  
March 26, 1922, to March 28, 1922,  
that I last saw him alive on March 28, 1922,  
and that death occurred, on the date stated above, at 5:05 P. M.

The CAUSE OF DEATH\* was as follows:

Peritonitis (Localized) OVER

CONTRIBUTORY  
(Secondary)18 Where was disease contracted  
if not at place of death? 2225 St. Paul St.

Did an operation precede death? Yes Date of March 26, 22

Was there an autopsy? Partial

What test confirmed diagnosis?

(Signed) P. M. D.

19 (Address) Union Mem. Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park Cem

DATE OF BURIAL

3-30-22

20 UNDERTAKER

Henry A. Jenkins &amp; Sons Co

ADDRESS

McLellan  
Orchard

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plauter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Origin unknown.*  
*No further history.*  
*Retrocecal Abscess extending to the*  
*liver. Peritonitis secondary. Cause of death*  
*unknown. No post-mortem* C.H.J.

D 62938 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62938

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH USV Hospital #56, Ft. McHenry, Md.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Fort McHenry, Md. ST. 3 WARD)

2-FULL NAME Luther H. Collins

(a) RESIDENCE No. USV Hospital #56, Ft. McHenry, Md. WARD 31

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 32 -- -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Miner 86

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer --

9 BIRTHPLACE (city or town) Md. (State or country) --

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant E.T. Rosenbrock (Registrar)

(Address) USV Hospital #56, Md.

15 MAR 30 1922 ROBERT R. KRAUTER Registrar

Social Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1922.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24 1922 to March 28th, 1922, that I last saw him alive on March 28th, 1922, and that death occurred, on the date stated above, at 11:20 A.M. The CAUSE OF DEATH\* was as follows:

Paralysis ascending acute (landry's paralysis)

-- (duration) -- yrs. -- mos. -- ds.

CONTRIBUTORY -- (Secondary)

(duration) -- yrs. -- mos. -- ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Clinical report

(Signed) H. J. Fisher, M. D.

3-28-22 Address USV Hospital #56, Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Blaine W. Va

20 UNDERTAKER

S. Quinlan

DATE OF BURIAL

3/29 1922

ADDRESS 1127

E. Balda

This statement should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 62939

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 832 Borne Alley ST. 18 WARD)

## 2-FULL NAME

George Arthur Hill

## (a) RESIDENCE

No. 832 Borne Alley ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 28 / 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8

27

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Roland Hill

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

North Carolina

12 MAIDEN NAME OF MOTHER

Alice Bean

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

North Carolina

14

Informant

(Address)

Roland Hill

832 Borne Alley

15

MAR 29 1922

ROBERT R. KRAUTER,

Burial Permit Clerk, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1922

17

I HEREBY CERTIFY That I attended deceased from

March 28, 1922, to March 29, 1922.

that I last saw him alive on March 29, 1922.

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH\* was as follows:

Convulsions + Broncho Pneumonia

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration)

yrs.

mos.

3 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Dr. W. H. H. M. D.

3-29-22 Address 708 Eusebe St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn Cem.

Apr 30 1922

20 UNDERTAKER

ADDRESS

Brown &amp; Eschard 414 9 Schrock

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection present*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62940

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

WARD)

## 2-FULL NAME

(a) RESIDENCE. No.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

MAR 29 1922 ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
Mar 22, 1922, to Mar 28, 1922.  
that I last saw her alive on Mar 28, 1922,  
and that death occurred, on the date stated above, at 11 a. m.  
The CAUSE OF DEATH\* was as follows:

Broncho-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed)

Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 62941

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62941  
Registered No. C

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 3326 Frederick Ave. St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

James A. Council  
(Residence in Baltimore: No. 3435 Greenmount Ave. St., yrs. 48 mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male  
4-COLOR OR RACE, White  
5-Single, Married, Widowed, or Divorced, (Write the word.)6-DATE OF BIRTH, Feb. 12, 1888  
(Month) (Day) (Year)7-AGE, 67 yrs. 1 mos. 14 ds.  
If LESS than 1 day, hrs. or min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, Brush maker  
(b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Virginia

10-NAME OF FATHER, James E. Council

11-BIRTHPLACE OF FATHER, (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Sarah A. White

13-BIRTHPLACE OF MOTHER, (State or Country), Virginia

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), E. K. Council

(Address), 3435 Greenmount Ave.

## 15-

Filed MAR 29 1922 ROBERT R. KRAUTER,  
Burial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 28, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:  
Aneurysm Rectoris

CONTRIBUTORY (Duration) 0 yrs. mos. ds.

artery (Secondary) ruptured Coronary

(Signed) James H. Fulton M. D.  
(Coroner.)

Mar 29 1922 (Address) 700 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, London Park DATE OF BURIAL, Mar 30, 1922

20-UNDERTAKER, Geo. W. Little ADDRESS 2700

N. B.—Every item of information should be properly classified. Exact statement of state CAUSE OF DEATH in plain terms, so that it may be properly classified, is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62942

## CERTIFICATE OF DEATH.

D 62942

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 RIDGELY

ST.: WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JOHN L SCHEMM

(a) RESIDENCE. No. 810 RIDGELY  
(Usual place of abode)

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced (write the word)

Male

WHITE

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

ERNESTINE

6 DATE OF BIRTH (month, day, and year) JUN JUNE 1866

7 AGE 55 Years 2 Months 28 Days

If LESS than  
1 day. hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

LABORER

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

NOTKNOWN

9 BIRTHPLACE (city or town)  
(State or country)

MARYLAND

10 NAME OF FATHER

JOHN L SCHEMM

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

GERMANY

12 MAIDEN NAME OF MOTHER

NOT KNOWN

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Germany

14

Informant  
(Address)

Ernestine Schemm

810 Ridgely Street

15

Filed

19

ROBERT R. KRAUTER

MAR 29 1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-28-1922

17

I HEREBY CERTIFY, That I attended deceased from  
3-28, 1922, to 3-28, 22, 1922.

that I last saw him alive on 3-28-22, 1922.

and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH\* was as follows:

Angina Pectoris.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Shepherd Driscoll, M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

John Grebliauckas

ADDRESS

425 S Paca  
St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62943

62943

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

JOHNS HOPKINS HOSPITAL ST.

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Elizabeth Franklin

## (a) RESIDENCE NO.

Fairfield, Md.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Unknown

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

X

6 DATE OF BIRTH (month, day, and year)

Apr 28, 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5

28

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

X

OOD

(b) General nature of industry, business, or establishment in which employed (or employer)

X

(c) Name of employer

X

9 BIRTHPLACE (city or town) (State or country)

Fairfield Md.

10 NAME OF FATHER

Walter Franklin

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Bernie Wilson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Penn

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

Records

15

MAR 29 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 28, 1922

17

I HEREBY CERTIFY, That I attended deceased from 3/28/22 at 9<sup>00</sup> P.M. to 3/28/22 - 11<sup>30</sup> P.M. that I last saw her alive on March 28<sup>th</sup>, 1922, and that death occurred, on the date stated above, at 11<sup>30</sup> / 9 m. The CAUSE OF DEATH\* was as follows:

Pneumococcus meningitis - (Primary focus not known) - (duration) yrs. mos. / ds.

CONTRIBUTORY (Secondary)

None

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Lumbar puncture

(Signed)

Horace E. Brewster, M. D.

(Address)

Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Furnace Branch

DATE OF BURIAL

Mar 30, 1922

20 UNDERTAKER

John H. Denny

ADDRESS

715 Light St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62944

## CERTIFICATE OF DEATH.

REGISTERED No.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1141 Wicomico* ST. *71* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Henrietta Spremer*(a) RESIDENCE. No. *1141 Wicomico* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *66* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *George Spremer*6 DATE OF BIRTH (month, day, and year) *Nov. 11, 1848*7 AGE Years *73* Months *4* Days *16* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Home Duties*

(b) General nature of industry, business, or establishment in which employed (or employer)

*at Home*

(c) Name of employer

9 BIRTHPLACE (city or town) *Richmond Va.* (State or country)10 NAME OF FATHER *Frederick Chamberberg*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)14 Informant *John Spremer* (Address) *1141 Wicomico St*15 Filed *Robert P. Harrison* Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 27 1922*17 I HEREBY CERTIFY, That I attended deceased from *Mar 25, 1922*, to *Mar 27, 1922*, that I last saw him alive on *Mar 27, 1922*, and that death occurred, on the date stated above, at *5 P. M.*

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*(duration) yrs. mos. *2* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *yes*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Wm. H. Hoag*, M. D.3/30 1922 (Address) *724 Columbia Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Western Cemetery* *March 31, 1922*

20 UNDERTAKER

ADDRESS

*Charles John H. Puffer & Son* *801 N. Fayette St.*

R 29 1922



D 62946

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62946

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 527 E Gitting St.

ST. 24 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Loeber

(a) RESIDENCE. No. 527 E. Gitting St.  
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 2 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Rudolph Loeber

6 DATE OF BIRTH (month, day, and year) Jan. 11 1873

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
49 2 17

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.  
(State or country)

10 NAME OF FATHER Edw. Buettner

11 BIRTHPLACE OF FATHER (city or town) Germany  
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) "  
(State or country)14 Informant Mr. Rudolph Loeber  
(Address) 527 E. Gitting St.

15 Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/28-22

17 I HEREBY CERTIFY, That I attended deceased from

Jan. 10, 1922 to Mar. 10, 1922

that I last saw her alive on Mar. 27, 1922

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Cervix Uteri.

From family history, duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Case inoperable Date of Did an operation precede death?

Was there an autopsy? No

What test confirmed diagnosis? St. Agnes - hospital

(Signed) Mary F. Daiglen, M. D.

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Carmel Cem 3/31 1922

20 UNDERTAKER ADDRESS

J. F. Mc Gally 130 E. Fox

MAR 29 1922

Burial Permit Clerk.



94-2383

Form 6-9-19 H. P. Co. 1000 Bkr.

D 62947

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62947

11-001

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Nursery & Child's Hosp.* WARD)

2-FULL NAME

*Margaret Gallagher*

(a) RESIDENCE. No. *Nursery & Child's Hosp.* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female White*

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Aug. 25, 1920*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*1*

*6*

*14*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Camden, N.J.*

10 NAME OF FATHER

*Joseph Gallagher*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

*Margaret Uppler*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*New Jersey*

14

Informant (Address)

*Robert P. Harrison*

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

*Conradson & Co.*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 11<sup>th</sup>, 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar 2<sup>nd</sup>, 1922, to Mar. 11<sup>th</sup>, 1922,*

that I last saw her alive on *Mar 11<sup>th</sup>, 1922,*

and that death occurred, on the date stated above, at *9:25 P.m.*

The CAUSE OF DEATH\* was as follows:

*Broncho Pneumonia*

(duration) yrs. mos. ds. *3*

CONTRIBUTORY (Secondary)

*La Grippe*

(duration) yrs. mos. ds. *9*

18 Where was disease contracted If not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

*Wm. J. Keating* M. D.

(Address)

*1000 E. Pratt St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

*MAR 29 1922*

ADDRESS

Information should be carefully supplied, so that it may be properly classified. Exact statement of occurrence of death in plain terms, so that it may be properly classified. See instructions on back of certificate.

R 9 1922

Bureau of Health Registrar

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

body at city morgue  
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62948

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 111 Scott St.)

ST. 18 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mallory Johnson

(Residence in Baltimore: No. 111 Scott St.)

St.: yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

Color

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH

Don't know

7-AGE

65

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Housework

9-BIRTHPLACE.  
(State or Country).

Pa

10-NAME OF FATHER

Don't know

11-BIRTHPLACE OF FATHER  
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Robert P. Harrison,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

March 17, 1912

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an

thereon and from the evidence obtained by said

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Valvular Heart disease

(Duration) yrs. mos. da.

CONTRIBUTORY Don't know

(Duration) yrs. mos. da.

(Signed) J. J. Gorman, M. D.

3-28-1912 (Address) 117 W. Lexington

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Continental Health

MAR 29 1922

Per. Wm. S. WOODHALL

7291922

Burial Permit

MORQUE.

D 62949 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62949

1-PLACE OF DEATH Bayview Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (NO

ST. 76 WARD)

2-FULL NAME

Mary Perkins

(a) RESIDENCE. NO.

Unknown

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Do. yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female Black

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1877

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia Unknown

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Do

12 MAIDEN NAME OF MOTHER

Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Do

14

Informant (Address)

Bayview Hospital Baltimore, Md.

15

Filed

91922

Report of Death

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 20, 1922

17

I HEREBY CERTIFY, that I attended deceased from July 23, 1908 to March 20, 1922 that I last saw him alive on March 20, 1922

and that death occurred, on the date stated above, at 3:00 P. M.

The CAUSE OF DEATH\* was as follows:

Acute Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocardial Clotting

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

No

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

H. Alderson, M. D.

(Signed)

3/29/22

19

Address Bayview Hospital

State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

HOPKINS HOSPITAL

20 UNDERTAKER

ADDRESS

Commissioner of Health

MAR 29 1922

D 62950

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62950

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO) Municipal Tuberculosis Hospital WARD 31

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Parker

(a) RESIDENCE. No. 222 Myrtle Ave.  
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE Years 18 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER Richard Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Anna Rutter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant, Hospital Records (Address) M.T.H.

JOHN

19 PLACE OF BURIAL, CREMATION OR REMOVAL

HOPKINS HOSPITAL

DATE OF BURIAL

19

20 UNDERTAKER

J. M. HARRISON

ADDRESS

MAR 29 1922

Information should be carefully supplied. After amount to be supplied, so that it may be properly classified. Exact statement of occupation should be supplied. See instructions on back of certificates.

AH 8 31922

Robert P. Harrison

Registrar

Bureau of Health

Per. W. H. WOODALL



HEALTH DEPARTMENT—CITY OF BALTIMORE **D 62951****D 62951**

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *939 N. Dallas* ST.: *7* WARD)2-FULL NAME *Margaret M. Lober*(a) RESIDENCE. NO. *939 N. Dallas* ST.: WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. *9* mos. *10* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *June 19 1921*

7 AGE Years *9* Months *10* Days *10* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *nurse*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *MD*10 NAME OF FATHER *Fredrick J. Lober*11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country) *MD*12 MAIDEN NAME OF MOTHER *Anna E. Gallagher* (Address) *1223 N. Carolina*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country) *MD*14 Informant *Mr. Frederick J. Lober* (Address) *939 N. Dallas*15 Filed *Robert P. Harrison*, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 29-1922*

17 I HEREBY CERTIFY, That I attended deceased from *Mar. 13*, 1922, to *Mar. 29*, 1922 that I last saw her alive on *March 29*, 1922 and that death occurred, on the date stated above, at *10 a. m.* The CAUSE OF DEATH\* was as follows:

*Measles*

CONTRIBUTORY (Secondary)

*Bronchopneumonia* (duration) *20* yrs. *7* mos. *7* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Edwin B. Fenby*, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*New Cathedral Cemetery* DATE OF BURIAL *Mar 30 1922*

20 UNDERTAKER

*Henry Hreck Sen* ADDRESS *1301 E. Bay*

tion should be carefully supplied. Also should be supplied in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

AR 2 91922

D 62952

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62952

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 N. Central Ave. 10 WARD)2-FULL NAME Charles E. Scheff(a) RESIDENCE NO. 825 N. Central Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 9 mos. 24 ds. How long in U. S., if of foreign birth? 100 yrs. 00 mos. 00 ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) June 5, 19207 AGE Years 1 Months 9 Days 24 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore  
(State or country) md10 NAME OF FATHER Charles D. Scheff11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country) md12 MAIDEN NAME OF MOTHER Bessie Cook13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country) md14 Informant Mr. Charles D. Scheff  
(Address) 825 N. Central Ave.15 Robert P. Harrison Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29, 192217 I HEREBY CERTIFY, That I attended deceased from Mar 28, 1922 to Mar 29, 1922, that I last saw him alive on Mar 24, 1922, and that death occurred, on the date stated above, at 10:30 a.m.  
The CAUSE OF DEATH\* was as follows:  
Pneumonia(duration) yrs. mos. 3 ds.CONTRIBUTORY (Secondary) Pneumonia(duration) yrs. mos. 1 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physician's report(Signed) Wm. H. Hickey M. D.19 Henry Hickey (Address) 1301 E. Egan

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 Henry Hickey (Address) 1301 E. Egan20 UNDERTAKER Henry Hickey

DATE OF BURIAL

Mar 31, 1922

ADDRESS

1301 E. Egan

Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 29 1922

Burial Permit Clerk

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name organ; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior*

D 62953

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 62953

## CERTIFICATE OF DEATH.

100-001

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3326 Myrtle Place ST. 76 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul M. Fisher

(a) RESIDENCE No. 3247 Philadelphia Ave.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 16-1921

7 AGE Years 1 Months 12 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

10 NAME OF FATHER Chas. J. Fisher

11 BIRTHPLACE OF FATHER (city or town) City

(State or country)

12 MAIDEN NAME OF MOTHER Margaret Davis

13 BIRTHPLACE OF MOTHER (city or town) North Carolina

(State or country)

14

Informant Chas. J. Fisher

(Address) 3247 Philadelphia Ave.

15

Robert S. Harrison,

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 28 1922

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1922, to March 28, 1922.

that I last saw him alive on March 27, 1922, at 6:25 a.m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Prominent Inflammation (duration) yrs. mos. 2 ds.

CONTRIBUTORY acute tonsillitis (Secondary) (duration) yrs. mos. 3 ds.

18 Where was disease contracted? 3247 Philadelphia Ave. if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinal

(Signed) M. D.

3/29, 1922 (Address) 3207 E. Baltimore St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt. Carmel Cem. 3-30-22

20 UNDERTAKER J. A. Moran ADDRESS 300 E. Baltimore St.

Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MAR 29 1922

BUREAU OF HEALTH



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62954

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE:

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

WARD.

(If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Robert P. Harrison,

Registrar

AR 2 9 1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1922

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1922, to March 29, 1922, that I last saw her alive on March 29, 1922, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH\* was as follows:

Diphtheria, Auricular &amp; pharyngeal

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 15

acute myocarditis

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

culture pos.

(Signed)

B. L. Crawford, M. D.

(Address) Sydenham Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Nehem Rosedal

DATE OF BURIAL

3/29 1922

20 UNDERTAKER

Jueh Lewis 1439 E. Baltimore

## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 62955

D 62955

## CERTIFICATE OF DEATH.

31

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1413 Morling Ave ST. 13 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. 1413 Morling Ave ST.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced  
HUSBAND of CHAS W. Dietch  
WIFE of

6 DATE OF BIRTH (month, day, and year) May 9, 1900

7 AGE Years 21 Months 10 Days 19 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) Bedford Pa (State or country)

## 10 NAME OF FATHER J. B. Golden

## 11 BIRTHPLACE OF FATHER (city or town) Penna (State or country)

## 12 MAIDEN NAME OF MOTHER Mary O'Leary

## 13 BIRTHPLACE OF MOTHER (city or town) Penna (State or country)

## 14

Informant J. B. Golden (Address) 1413 Morling Ave

## 15

Filed

Robert P. Harrison, Registrar

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Mar 16, 1922, to Mar 28, 1922

that I last saw him alive on Mar 28, 1922.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Tumor coptic finding

(Signed) B. A. Fieich

M. D.

3/28/22 (Address) 1413 Morling Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Woodlawn Cemetery

Mar. 31, 1922

## 20 UNDERTAKER

ADDRESS 1944

Harry W. Ehlen

W. North

AR 2 91922

Burial Permit Clerk.

Information should be carefully supplied. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-

D 62956

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62956

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Anne's Hospital*)

## 2. FULL NAME

*William Mariellus Shoemaker*

## (a) RESIDENCE NO.

*1022 N. Calvert*ST. *11* WARD

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(Usual place of abode)

Length of residence in city or town where death occurred

*82* yrs. *0* mos. *28* ds.

How long in U. S., if of foreign birth?

*82* yrs. *0* mos. *28* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Single*

6 DATE OF BIRTH (month, day, and year)

*March-1-1840*

7 AGE

*82*

Years

Months

*0*

Days

*28*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED,

(a) Trade, profession or particular kind of work

*Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

*none*

(c) Name of employer

*none*

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Maryland*

10 NAME OF FATHER

*Wm. S. Shoemaker*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Phila. Penna*

12 MAIDEN NAME OF MOTHER

*Rebecca Grace*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Balls. Md*

14

Informant (Address)

*J. P. J. McElhenny (nephew) 2000 N. Calvert St. Baltimore, Md*

15

Filed

*Robert P. Harrison,*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*March 28 22*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 17*

1921, to

*March 28, 19 22*

that I last saw him alive on

*March 28, 19 22*

and that death occurred, on the date stated above, at

*6:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Eptoris sepirose & hypertension*(duration) *2* yrs. *0* mos. *0* ds.

CONTRIBUTORY (Secondary)

(duration) *0* yrs. *0* mos. *0* ds.

18 Where was disease contracted if not at place of death?

*?*

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*W. W. Scott*

M. D.

19

(Address)

*St Agnes Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*MOVAL**Linden Park Cemetery*

DATE OF BURIAL

*May 31, 19 22*

20 UNDERTAKER

*STEWART & MOWEN COMPANY*

(WILLIAM F. WOODEN, Successor)

ADDRESS

*108 W. NORTH AVE.*

R 291922

Burial Permit Clerk.

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 62957

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

5 D 62957

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1624 St Joseph

ST.: 8

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Annie Blake

(a) RESIDENCE. NO.

1624 St Joseph

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 2 mos. 7.6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 2 1853

7 AGE

69

Years

Months

2

Days

26

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

Housekeeper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Annie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Mr. John Blake 1624 St Joseph St

15

MAR 3 01922

ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28<sup>th</sup> 192217 I HEREBY CERTIFY, That I attended deceased from March 24<sup>th</sup> 1922, to March 28<sup>th</sup> 1922.that I last saw her alive on March 27<sup>th</sup> 1922.

and that death occurred, on the date stated above, at 5:30 A. M.

The CAUSE OF DEATH was as follows:

Malaria and Nephritis  
attended with a severe case.  
Refused all treatment for four days.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Acute Nephritis

18 Where was disease contracted if not at place of death?

At her home

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

, 19 (Address)

Samuel J. Bell, M. D.  
1516 E. Preston St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oakley Cemetery

DATE OF BURIAL

March 31, 1922

20 UNDERTAKER

Mrs Robert A. Elliott

ADDRESS

Oakland



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Clinical diagnosis.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62958

## CERTIFICATE OF DEATH.

91-008 D 62958  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1316 N. Central ave ST.; 9 WARD)

(If death occurred in a hospital, or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Novella E. Johnson(Residence in Baltimore: No. 1316 N. Central ave St.; 18 yrs., mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE

White

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

widow

## 6-DATE OF BIRTH

Aug 31, 1882  
(Month) (Day) (Year)

## 7-AGE

69 yrs., 6 mos., 28 ds.

## If LESS than 1 day,

...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

retired

## 9-BIRTHPLACE, (State or Country).

Va.

## 10-NAME OF FATHER

Charles E. Loggill

## 11-BIRTHPLACE OF FATHER (State or Country).

Va

## 12-MAIDEN NAME OF MOTHER

Mary J. Mitchell

## 13-BIRTHPLACE OF MOTHER (State or Country).

N.C.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary J. E. Ekins(Address) 1316 N. Central ave

## 15-

Filed

MAR 3 0 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

March 29, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Feb 20 1922, to March 29 1922,that I saw her alive on March 28 1922,and that death occurred, on the date stated above, at 4:55 a.m.

The CAUSE OF DEATH\* was as follows:

arteriosclerosis(Duration) 2 yrs., 5 mos., 5 ds.CONTRIBUTORY (Secondary) Polymyositis(Duration) 5 yrs., 5 mos., 5 ds.(Signed) Robert R. Krauter M. D.March 29, 1922 (Address) 1316 N. Central Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

Richmond & N. E. Ave.

## DATE OF BURIAL

March 31, 1922

## 20-UNDERTAKER

John Mitchell

## ADDRESS

12016 Bayette

N. B.—Every return of death must be properly classified. Exact statement of occupation must be in plain terms, so that it may be properly classified. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62959

## CERTIFICATE OF DEATH.

46 D 62959

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2122 N Calvert ST., 12 WARD)

## 2-FULL NAME

Mildred Gunter Pittenhouse

## (a) RESIDENCE NO.

2122 N Calvert ST., 12 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

female

## 4 COLOR OR RACE

white

## 5 Single, Married, Widowed, or Divorced, (write the word)

married

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John B. Gunter

## 6 DATE OF BIRTH (month, day, and year)

Oct 1879

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

425

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

Retired

## 9 BIRTHPLACE (city or town) (State or country)

Alabama

## 10 NAME OF FATHER

John B. Gunter

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Alabama

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

## 14

Informant (Address)

John B. Gunter  
2122 N Calvert St

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Mar 25 1922

## 17

I HEREBY CERTIFY, That I attended deceased from Feb 2, 1922, to Mar 27, 1922.that I last saw her alive on Mar 27, 1922.and that death occurred, on the date stated above, at 5:40 m.

The CAUSE OF DEATH\* was as follows:

Sacromatous degeneration  
of uterine fibroma(duration) yrs. 8 mos. ds.

## CONTRIBUTORY (Secondary)

Invasion by sarcoma  
in abdominal organs (duration) yrs. 6 mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct 1921

## Was there an autopsy?

yes

## What test confirmed diagnosis?

Pathological

## (Signed)

John B. Gunter, M. D.

## (Address)

1008 Cathedral

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park Rd Mar 30 1922

## 20 UNDERTAKER

John Mitchell 1201 N. Fayette

MAR 30 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62960

## CERTIFICATE OF DEATH.

161-001  
D 62960

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2120 S Charles ST. 23 WARD)

## REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. 2120 S Charles ST. 23 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Mar 25/22

## 7 AGE

Years

Months

Days

If LESS than  
1 day, / hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

000

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore  
Md.

## 10 NAME OF FATHER

Edgar Rekey11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Baltimore  
Md.

## 12 MAIDEN NAME OF MOTHER

Ida P. Meyers13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Baltimore  
Md.

## 14

Informant  
(Address)Edgar Rekey  
2120 S Charles St.

## 15

ROBERT R. KRAUTER  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Mar 25, 1922, to Mar 25, 1922that I last saw him alive on Mar 25, 1922and that death occurred, on the date stated above, at 9-15 P.M.

The CAUSE OF DEATH\* was as follows:

Premature Birth  
6 Mo. utero gestation

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Plumage  
Mar 25, 1922 (Address) 1644 Hancock

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Barnel Cemetery

## DATE OF BURIAL

Mar 30, 22

## 20 UNDERTAKER

John F. Denny

## ADDRESS

715 Light

mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 30 1922



D 62961

Baier  
HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D 62961

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 30 Grindon Ave

ST.: 44 WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 31 Grindon Ave

St.: 50 yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE,

White

## 5-SINGLE,

MARRIED, married  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

August 14, 1851.  
(Month) (Day) (Year)

## 7-AGE,

70 yrs. 7 mos. 14 ds. If LESS than 1 day, hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Retired Baker  
Himself 8039-BIRTHPLACE,  
(State or Country),

Balto Md

## 10-NAME OF FATHER,

John Baier

11-BIRTHPLACE OF FATHER  
(State or Country),

Germany

## 12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER  
(State or Country),

Germany

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Baier

(Address) 30 Grindon Ave

## 15-

MAR 3 0 1922

191

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Mar 28, 1922  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

Jan 2 1922 to Mar 28 1922

that I saw him alive on Mar 28 1922

and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH\* was as follows:

Exhaustion &amp; T. M.

(Duration) yrs. mos. ds.

## CONTRIBUTORY

(Secondary)

Exhaustion &amp; T. M.

(Signed) Charles J. Murray M. D.

Mar 28 1922 (Address) 4700 N. E. St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Holy Redeemer Cemetery

Mar 30, 1922

## 20-UNDERTAKER

## ADDRESS

George - J. Ruth 1735 Hayford Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62963

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 248 White Ave / Hamlet WARD)

## 2-FULL NAME

(a) RESIDENCE

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds.How long in U. S., if of foreign birth 50 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male White married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Laura E Morgan

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

Sept 28 / 184377 6

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BlacksmithRetired

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAR 30 1922

ROBERT R. BRAUTER Registrar

Burial Permit

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28, 192217 I HEREBY CERTIFY, That I attended deceased from Feb., 1905, to Mar. 28, 1922.that I last saw him alive on Mar. 27, 1922.and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH\* was as follows:

Arterio-SclerosisCONTRIBUTORY (Secondary) (duration) 2 yrs. mos. ds. Chronic interstitial Nephritis

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical(Signed) H. C. Hoess, M. D.3-29, 1922 (Address) 5600 York Rd.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Green Park Cemetery 1922

20 UNDERTAKER

William C. C. & Co.

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. SECTION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62964

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 62964

1-PLACE OF DEATH

City of BALTIMORE: (No. South Balto. General Hospital, 25 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....Margaret E. Miller. (C).....

(Residence in Baltimore: No. 3rd. Ave. & 5th. St. Fairfield, .....St.; yrs. 5 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.....Female.....  
4-COLOR OR RACE.....White.....  
5-Single, Married, Widowed, or Divorced, (Write the word.).....Single

6-DATE OF BIRTH.....October 20th, 1921.....  
(Month) (Day) (Year)

7-AGE.....5 mos. 8 ds.....  
If LESS than 1 day, .....hrs. or .....min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work.....None.  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),.....Baltimore, Md.

PARENTS:  
10-NAME OF FATHER.....Ashby Miller. (C)  
11-BIRTHPLACE OF FATHER, (State or Country),.....Caroline Co. Md.  
12-MAIDEN NAME OF MOTHER.....Willie May Vanders.  
13-BIRTHPLACE OF MOTHER, (State or Country),.....Anderson, S. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant).....Willie May Miller. (C) mother  
(Address).....3rd. Ave. & 5th. St. Fairfield

15-  
Filed MAR 3 0 1922  
ROBERT E. KRAUTER  
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.....March 28th, 1922.....  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry.....  
(Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said inquiry.....  
(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:  
.....Broncho-pneumonia.  
.....Unknown.  
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....  
(Duration).....yrs.....mos.....ds.  
(Signed).....M. D. (Coroner.)  
March 28, 1922 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).  
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.  
Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.  
Mt Auburn 1922

20-UNDERTAKER, ADDRESS  
E. Brown 1877 Monty



N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62965

## CERTIFICATE OF DEATH.

D 62965

### PLACE OF DEATH

CITY OF BALTIMORE (No. *511 Bruner*)

ST.

WARD)

### FULL NAME

*Annie M. Wright*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *511 Bruner*)

St. *Life* mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

#### 3-SEX

*F*

#### 4-COLOR OR RACE

*White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

#### 6-DATE OF BIRTH

*Oct 25, 1865*  
(Month) (Day) (Year)

#### 7-AGE

*56 yrs. 3 mos. 3 ds.*

If LESS than 1 day, ...hrs. or ...min.?

#### 8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

*Home 037*

#### 9-BIRTHPLACE

(State or Country).

*Baltimore*

#### 10-NAME OF FATHER

*Christian Robert*

#### 11-BIRTHPLACE OF FATHER

(State or Country).

*Germany*

#### 12-MAIDEN NAME OF MOTHER

*Katherine Robert*

#### 13-BIRTHPLACE OF MOTHER

(State or Country).

*Germany*

#### 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

*Jac. H. Wright  
511 Bruner St.*

#### 15-

MAR 3 0 1922

ROBERT H. KRAUTER

Registrar

### CORONER'S CERTIFICATE OF DEATH.

#### 16-DATE OF DEATH

*Nov 28, 1922*  
(Month) (Day) (Year)

#### 17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

And that said deceased came to death (Inquest, au-

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Chronic Parenchymatous Nephritis*  
(Duration) *18* yrs. *0* mos. *0* ds.

#### CONTRIBUTORY (Secondary)

(Duration) *18* yrs. *0* mos. *0* ds.

(Signed) *J. H. Krauter* M. D.

(Coroner.)

*March 10, 1922* (Address) *2802 E. Main St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

#### 18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

#### Former or usual residence

#### 19-PLACE OF BURIAL, OR REMOVAL

*Waverly*

#### DATE OF BURIAL

*Nov 30, 1922*

#### 20-UNDERTAKER

*H. M. Cork*

#### ADDRESS

*N. B. M. Co.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

D 62966

CITY OF BALTIMORE (No. *St Joseph Hospital* ST. 7

2-FULL NAME *Carrie M. Welch*

(Residence in Baltimore: No. *821 A Caroline St*

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

1-SEX. *Female*

2-COLOR OR RACE. *White*

3-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*  
(Write the word.)

6-DATE OF BIRTH, *Nov 4th*, 1895

(Month)

(Day)

(Year)

7-AGE, *26* yrs., *4* mos., *24* ds.

If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. ....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Baltimore Md*

10-NAME OF FATHER, *Wm J Walch*

11-BIRTHPLACE OF FATHER (State or Country), *Baltimore Md*

12-MAIDEN NAME OF MOTHER *Rose Alstein*

13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *George E. Walch*

(Address) *821 A Caroline*

15-

MAR 3 0 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Mar 28th*, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I am in charge of the remains described above, held as *Coroner* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Coroner* (Inquest, autopsy or inquiry.)

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*suicide by gunshot*  
(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(Signed) *J. H. P. P. P.* (Coroner) ....

3:29 PM, 1922 (Address) *44 E. E. E.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, *New Cathedral*

DATE OF BURIAL, *Mar 31, 1922*

20-UNDERTAKER, *Robt L Turner*

ADDRESS *144 E Broadway*

MORE 001  
74-D 62967

REGISTERED NO

# 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1616 Eutaw Pl.* ST. *14* WARD)

2-FULL NAME.. *Anne Fultou Agnew*

(a) RESIDENCE, NO. 1616 E. 1st St. Apt. 101

(a) RESIDENCE. No. 1616 Central Ave. ST. CHICAGO WARD. 12  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred 50 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

3 SEX Female	4 COLOR OR RACE white	5 Single, Married, Widowed or Divorced (write the word) Married
-----------------	--------------------------	---

5a If married, widowed, or divorced  
~~HUSBAND~~  
(or) WIFE of *Gen's Felix Agnus*

6 DATE OF BIRTH (month, day, and year) 1840-9-29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	6	—	

8 OCCUPATION OF DECEASED *Lady* 037

(b) General nature of industry, business, or establishment in which employed (or employer) *at Home*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER *Charles Carroll Fulpo*

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Phila - Pa*

12 MAIDEN NAME OF MOTHER Emily Timmerly

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Balto Md

14 Informant Mrs. Oscar Heiser  
(Address) 4116 E. 1st St. S. E.

15 Filed 19 ROBERT R. KRAUTER, Resident

MAR 3 0 1922 Burial Permit Clerk.

16 DATE OF DEATH (month, day, and year) 3-29 1927

17 I HEREBY CERTIFY, That I attended deceased from  
March 22, 1922, to March 29, 1922.

that I last saw Er alive on March 29, 1972.

and that death occurred, on the date stated above, at 4 1/2 m.

The CAUSE OF DEATH\* was as follows:

(duration) yrs. mos. / ds

CONTRIBUTORY  
(Secondary)

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Yes, Date of 11/1/50

4 Was there an autopsy?..... *Yes*

What test confirmed diagnosis? Chandharn M. I.

(Signed) \_\_\_\_\_  
19 (Address) 1327 Park Ave

\*State the Disease Causing Death, or in deaths from Violent Cause state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
--	----------------

David Red/E

20 UNDERTAKER  
 J. J. Campbell Co  
 1211 1/2 N. 1st St.  
 St. Paul, Minn.

Newyer Jansz 1860 Arthur

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62968

D 62968

## CERTIFICATE OF DEATH.

REGISTERED NO. ....

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *103 E 25<sup>th</sup>*)ST. *17* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Henry B. Vockse*(a) RESIDENCE. No. *103 E. 25<sup>th</sup>*

(Usual place of abode)

ST. .... WARD. ....

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* mos. ....

ds. How long in U. S., if of foreign birth? yrs. .... mos. .... ds. ....

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *June 3-1851*  
7 AGE Years *70* Months *8* Days *24* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto*10 NAME OF FATHER *Glaas Vockse*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Antonia*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14

Informant (Address) *Henry J. Krause 4017 Old York Road*

15

MAR 3 0 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 27<sup>th</sup>* 19 *22*17 I HEREBY CERTIFY, That I attended *from* *Dec 14<sup>th</sup>* 19 *21*, to *Mar 27<sup>th</sup>* 19 *22*, that I last saw him alive on *Mar 27<sup>th</sup>* 19 *22*, and that death occurred, on the date stated above, at *11:20 P* m.

The CAUSE OF DEATH\* was as follows:

*Diabetes Melitus*(duration) *3* yrs. *13* mos. *13* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? *L*Did an operation precede death? *No*Date of *L*Was there an autopsy? *No*What test confirmed diagnosis? *Chem + Physical Exam.*(Signed) *August Horn*

M. D.

1922 Address *40 E 25<sup>th</sup> St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Balto Cemetery**Mar 30 1922*

20 UNDERTAKER

ADDRESS

*F.A. Krause & Son 7031 Avenue*

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62969

D 62969

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 S Sharp ST. 22 WARD)

## 2-FULL NAME Elizabeth A Armiger

(a) RESIDENCE. NO. 521 S. Sharp. ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

widow

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Joseph G Armiger

6 DATE OF BIRTH (month, day, and year)

Feb 21 1847

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

75

1

8

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

at home

9 BIRTHPLACE (city or town) (State or country)

Md

10 NAME OF FATHER

James Parmer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Eliza Woodson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant. (Address)

Griffith Armiger 521 S. Sharp St

15

MAR 3 0 1922

19

EL

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 28 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 7, 1919, to March 28, 1922

that I last saw her alive on March 27, 1922

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. 6 mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. P. Erbenbach M. D.

Address) 1412 Light St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

West River A. A. Co Md Mar 30 1922

20 UNDERTAKER

ADDRESS

F. A. Krause &amp; Son 703 Hanover

Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 62970

90 D 62970

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 408 IV Fremont av ST. 18 WARD)

2-FULL NAME *Maria Atkinson*

(Residence in Baltimore: No. 408 IV Fremont av. 4 yrs., mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE. *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*  
6-DATE OF BIRTH. *Do not know*, 1 (Month) (Day) (Year)  
7-AGE. *27* yrs., mos. ds. If LESS than 1 day, ... hrs. or ... min.  
8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Housewife* (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country).

10-NAME OF FATHER. *N. Carolina*  
11-BIRTHPLACE OF FATHER. *Do not know*  
12-MAIDEN NAME OF MOTHER. *Do not know*  
13-BIRTHPLACE OF MOTHER. *Do not know*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Arthur Atkinson*  
(Address) *408 IV Fremont av*

15-

Filed *MAR 30 1922* 191. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

*March 27*, 19*22*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Voluntar Heart Disease*

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) *Do not know*

(Duration) yrs. mos. ds.

(Signed) *A. H. Gross* M. D.

*3.28.1922* (Address) *117 N. Janelle*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

*Norfolk Va* DATE OF BURIAL, *Mar 29 1922*

20-UNDERTAKER ADDRESS

*R. B. Gross 1405 McEldeeny*

N. B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

D 62971

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62971

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. 512 S. Bouldin St. Ward)

2-FULL NAME

(Residence in Baltimore: No. 512 S. Bouldin St.; yrs. mos. ds.)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female  
4-COLOR OR RACE, White  
5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, April 15, 1866  
(Month) (Day) (Year)

7-AGE, 55 yrs. 11 mos. 12 ds.  
If LESS than 1 day, hrs. or min.

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, Housework  
(b) General nature of industry, business, or establishment in which employed (or employer), at home

9-BIRTHPLACE, (State or Country), Baltimore Md.

10-NAME OF FATHER, Valentine Prehn

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Barbara Pfeiffer

13-BIRTHPLACE OF MOTHER, (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Conrad Auer

(Address) 512 S. Bouldin St.

15-

Filed

MAR 30 1922

192

ROBERT R. KRAUTER,

Registrar.

Burial Permit Clock

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. 27, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest, autopsy or inquiry.

Thereon and from the evidence obtained by said Inquest, autopsy or inquiry, I find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Ac Gastritis,  
(Excess of Diet)

CONTRIBUTOR (Secondary) Cardiac Arrest

(Duration) 1 hr. 15 min.  
(Signed) G. B. Braden, M. D.  
(Coroner) Mar 27 1922 14376 Bm

\*State of Disease, Cause of Death, or, in deaths from Violent Causes, State (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

Sacred Heart Cem.

DATE OF BURIAL,

March 31, 1922

20-UNDERTAKER,

Lilly and Zick

ADDRESS

403 S. Wolfe St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62972

## CERTIFICATE OF DEATH.

D 62972

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3440 Mt. Pleasant* ST., *76* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Margaret M. Schneider*

## (a) RESIDENCE NO.

*3440 Mt. Pleasant* ST.,

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Married*

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Frank G. Schneider*

## 6 DATE OF BIRTH (month, day, and year)

*July 8-1870*

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs  
or min.*51**8**20*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Housework*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)*at home*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore  
Md.*

## 10 NAME OF FATHER

*George H. Smallwood*

## 11 BIRTHPLACE OF FATHER (city or town)

*Harford Co  
Md.*

## 12 MAIDEN NAME OF MOTHER

*Salome Martin*

## 13 BIRTHPLACE OF MOTHER (city or town)

*Balto Co.  
Md.*

## 14

Informant  
(Address)*Frank G. Schneider  
3440 Mt. Pleasant*

## 15

MAR 3 0 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*March 28 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*March 20, 1922, to March 28, 1922,*that I last saw him alive on *March 28, 1922,*and that death occurred, on the date stated above, at *7.40* m.

The CAUSE OF DEATH\* was as follows:

*Emphysema of Lungs*

(duration)

yrs. *6*

mos.

ds.

CONTRIBUTORY  
(Secondary)*asthma*

(duration)

*5*

yrs.

mos.

ds.

## 18 Where was disease contracted

if not at place of death?

*at home*

Did an operation precede death?

*no* Date of *no*

Was there an autopsy?

*no*

What test confirmed diagnosis?

*usual*

(Signed)

*M. Schneider*

M. D.

(Address) *3307 E. Baetrum St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Sacred Heart Cem.*

## DATE OF BURIAL

*March 31 1922*

## 20 UNDERTAKER

*Lilly and Zeiler.*

## ADDRESS

*403 S. W. 1st*

N. B.—WRITE FULL NAME OF PHYSICIAN, Exact statement of OCCUPATION, CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



N. B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62973

(Rothenbucher) 001  
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3403 Mueller St. 76 Ward)

2-FULL NAME

(Residence in Baltimore: No. 3403 Mueller St. 38 St.; yrs. mos. ds.)

Registered No. C. 62973

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE male 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH Aug 9 1861 (Month) (Day) (Year)

7-AGE 60 yrs. 7 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

MAR 3 0 1922 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 29 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above. The CAUSE OF DEATH was as follows:

CONTRIBUTORY (Secondary)

(Signed) Secretary of Health (Coroner) March 29 1922 (Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

20-UNDERTAKER. ADDRESS.

D 62974

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 62974

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1415 Madison Ave.* ST. *11-002* WARD)2-FULL NAME *Nelson T. Childs*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. *1415 Madison* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *25* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *May Childs*6 DATE OF BIRTH (month, day, and year) *Dec 20 / 1884*7 AGE Years *32* Months *3* Days *4* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Collector*(b) General nature of industry, business, or establishment in which employed (or employer) *Furniture*(c) Name of employer *Beck & Co.*9 BIRTHPLACE (city or town) *Washington* (State or country) *D.C.*10 NAME OF FATHER *Samuel N. Childs*11 BIRTHPLACE OF FATHER (city or town) *Washington* (State or country) *D.C.*12 MAIDEN NAME OF MOTHER *Mary Phillip*13 BIRTHPLACE OF MOTHER (city or town) *Washington* (State or country) *D.C.*14 Informant *Mrs M. Childs* (Address) *1415 Madison Ave*15 *MAR 3 0 1922* ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 29 1922*17 I HEREBY CERTIFY, That I attended deceased from *Mar 25*, 19*22*, to *Mar 29*, 19*22*, that I last saw him live on *Mar 25*, 19*22*.and that death occurred, on the date stated above, at *2 A* m.

The CAUSE OF DEATH\* was as follows:

*Influenza*CONTRIBUTORY (Secondary) *Acute Dilatation of Heart* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinically* (Signed) *R. J. Campbell* M. D. (Address) *1644 Hancock St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Western* *3-31-1922*20 UNDERTAKER ADDRESS *517 N**H B Lanning & Son* *Schneider* *St*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62975

## CERTIFICATE OF DEATH.

D 62975

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2509 Mc Eldeny ST.: 7 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles U Ford(a) RESIDENCE. No. 2509 Mc Eldeny ST.: 7 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Edith Ford6 DATE OF BIRTH (month, day, and year) Nov. 25 / 1885

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

564

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)10 NAME OF FATHER Daniel Ford11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md. (State or country)12 MAIDEN NAME OF MOTHER May Ford13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md. (State or country)

14

Informant (Address) Mrs. Edith Ford  
2509 Mc Eldeny St.

15

MAR 3 1922

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 192217 I HEREBY CERTIFY, That I attended deceased from March 24, 1922, to March 29, 1922that I last saw him alive on March 29, 1922and that death occurred, on the date stated above, at 12:40 p. m.

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

pulmonary edema (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward J. Horak, M. D., 19 (Address) 821 N. Baltimore St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Edithman Island Church March 31 1922

20 UNDERTAKER ADDRESS

Jos. J. Hill 156 N. Luzerne Ave

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

WRITE PLAINLY - WITH UNFADING INK  
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT-CITY OF BALTIMORE

## CERTIFICATE OF DEATH

D 62976

REGISTERED NO. C

D 62976

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

ST

WARD)

St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than

1 day, hrs.

or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

10 NAME OF FATHER

PARENTS  
11 BIRTHPLACE OF FATHER  
(State or country)  
12 MAIDEN NAME OF MOTHER  
13 BIRTHPLACE OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15 MAR 30 1922

ROBERT R. KRAUTER,

Burial Permit REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on

and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH\* was as follows:

Contributory  
(SECONDARY)

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

Usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS





REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Patient operated upon for  
appendicitis and third  
degree prolapse. (29 yrs.  
duration).— 9/25/22. Developed  
cerebral hemorrhage. 3/26/22.  
J. W. Peyton M.D.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62978

## CERTIFICATE OF DEATH.

57 D 62978  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2844 N North ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ada Rose Kletsch(Residence in Baltimore: No. 2844 N North ave St.; 6 yrs., 6 mos., 6 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Female</u>	4-COLOR OR RACE, <u>White</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, <u>Married</u> (Write the word.)
6-DATE OF BIRTH, <u>December 25<sup>th</sup>, 1869</u> (Month) (Day) (Year)		
7-AGE, <u>62</u> yrs., <u>1</u> mos., <u>5</u> ds.		If LESS than 1 day, ...hrs. or...min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work, <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer), <u>03</u>		

PARENTS.	9-BIRTHPLACE, (State or Country), <u>Baltimore Md</u>
	10-NAME OF FATHER, <u>Peter Hammer</u>
	11-BIRTHPLACE OF FATHER (State or Country), <u>Baltimore Md</u>
	12-MAIDEN NAME OF MOTHER, <u>Sarah E. Shremaker</u>
	13-BIRTHPLACE OF MOTHER (State or Country), <u>Maryland</u>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. S. Hammer, M.D.(Address) 1929 Edmondson ave

15-

Filed..... 191.....

ROBERT R. KRAUTER,  
Burial Permit Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 28<sup>th</sup>, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 1<sup>st</sup>, 1916, to March 28<sup>th</sup>, 1922, that I saw her alive on March 28<sup>th</sup>, 1922, and that death occurred, on the date stated above, at 5:00 P.M.  
The CAUSE OF DEATH\* was as follows:  
Diabetes Mellitus  
(Duration) 7 yrs., 6 mos., 6 ds.CONTRIBUTORY.....  
(Secondary) (Duration) 7 yrs., 6 mos., 6 ds.(Signed) H. S. Hammer M. D.Mar 28<sup>th</sup>, 1922 (Address) 1929 Edmondson ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 6 yrs., 1 mos., 5 ds. In the 63 yrs., 1 mos., 5 ds. State MDWhere was disease contracted, if not at place of death? Home EdmondsonFormer or usual residence 2844 N North ave19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery DATE OF BURIAL, Mar. 31<sup>st</sup>, 192220-UNDERTAKER, Harry H. Wyle ADDRESS 15314 Malver 4

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 30 1922

D 62979

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62979

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 Mc Henry St. ST. 19 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Howard E. Miller

## (a) RESIDENCE NO.

1511 Mc Henry St.

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred lifer. mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1, 1917

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4429

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

## 10 NAME OF FATHER

William B. Miller

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md.

## 12 MAIDEN NAME OF MOTHER

Grace F. Miller

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

## 14

Informant (Address)

William B. Miller 1511 Mc Henry St.

## 15

MAR 30 1922

ROBERT A. KRAUTER Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

3/20/22

## 17

I HEREBY CERTIFY, That I attended deceased from

3-29-1922 to 3-30-1922that I last saw him alive on 3-30-1922and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH\* was as follows:

Septicemic shock

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

unknownDid an operation precede death? yes Date of 3-29-22Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

J. B. Hall

M. D.

19 (Address)

1411 North

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Loudon Park

## DATE OF BURIAL

Mar 30 1922

## ADDRESS

1531 W. Lombard

## 20 UNDERTAKER

Harry H. W. Lyke

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



D 62980

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62980

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1905 White

ST.: 20 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Magdeline Moals Guy

(a) RESIDENCE. NO. 1905 White

ST.

WARD.

Sparkes Md

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

unknown 5 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

colored

5 Single, Married, Widowed, or Divorced (write the word)

married.

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

William Guy.

6 DATE OF BIRTH (month, day, and year)

March 1902

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

20

—

27

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

house-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

— 037

(c) Name of employer

9 BIRTHPLACE (city or town)

Baltimore County Ind.

(State or country)

10 NAME OF FATHER

Marvin Moals

11 BIRTHPLACE OF FATHER (city or town)

Folk Co., Ind.

(State or country)

12 MAIDEN NAME OF MOTHER

Mary Eide.

13 BIRTHPLACE OF MOTHER (city or town)

Balto Co., Ind.

(State or country)

14

Informant

Wm Guy

(Address)

1905 White St.

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-28-1922

17

I HEREBY CERTIFY, That I attended deceased from

3-17-1922, to 3-28-1922,

that I last saw her alive on 3-27-1922,

and that death occurred, on the date stated above, at 8:40 a.m.

The CAUSE OF DEATH\* was as follows:

Acute Nephritis

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY  
(Secondary)

Influenza

(duration) — yrs. — mos. 17 ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urinalysis

(Signed)

Chester Riland,

M. D.

3-28, 1922 (Address) 2532 Edmondson Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Sparkes Md

Mar 31 1922

20 UNDERTAKER

Sparkes Station

ADDRESS

Edward Puggs 1463 Carey St

D 62981

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62981

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (NO. 10 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 1423 Wilb.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

## 4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

## 6-DATE OF BIRTH,

(Month)

(Day)

(Year)

## 7-AGE,

If LESS than 1 day,

75 yrs. mos. ds.

... hrs. or ... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE,

(State or Country).

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER

(State or Country).

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER

(State or Country).

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

Robert P. Harrison,

Registrar.

Burial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Traumatism run over by their car

## CONTRIBUTORY (Secondary)

(Signed)

(Coroner)

3:29 PM (Address) 48-11-11

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

## Former or usual residence.....

## 19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

## 20-UNDERTAKER

ADDRESS

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 3 07 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62982

D 62982

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 Westwood Ave. 15 WARD)

## 2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

33 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a. If married, widowed, or divorced, HUSBAND or (or) WIFE of

Adolph Blondheim

6. DATE OF BIRTH (month, day, and year)

Mar 16 - 1893

7. AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

76

9

12

## 8. OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

Germany

10. NAME OF FATHER

Joseph Weinberg

11. BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12. MAIDEN NAME OF MOTHER

Rose Stern

13. BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14.

Informant (Address)

Dr. Weinberg 2302 Madison

15.

Robert P. Harrison,

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year)

Mar 28 1922

17.

I HEREBY CERTIFY, That I attended deceased from March 28<sup>th</sup>, 1922, to March 28<sup>th</sup>, 1922, that I last saw him alive on March 28<sup>th</sup>, 1922, and that death occurred, on the date stated above, at 9 P. m. The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary)

Myocarditis

(duration) — yrs. — mos. 1 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis P. Hamburger, M. D.

29, 1922 (Address) 1207 E. 1st Place

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Chet Shalom

ADDRESS

20. UNDERTAKER

1182a. Broadway

— WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

AR 30 1922

MORE 74-001 D 62983

D 62983

CITY OF BALTIMORE: (NO. 23 E. Ostend St. ST. 72 WARD)

Mary Pfister.

23 E. Ostend St. ST. WARD 23

(If non-resident give city or town and State)

(a) RESIDENCE NO. \_\_\_\_\_ (Usual place of abode)  
Length of residence in city or town where death occurred 70 yrs. --- mos. 11 ds. How long in U. S., if of foreign birth? --- yrs. --- mos. --- ds.

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH (month, day, and year) March 28th 1922

17 I HEREBY CERTIFY, That I attended deceased from

I HEREBY CERTIFY, That I attended deceased from  
March 25th, 1922, to March, 28th, 1922.

that I last saw her alive on March 28th., 19 22.

and that death occurred, on the date stated above, at 1.45 p. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage.

(duration) . . . yrs. . . mos 4 . . . ds.

CONTRIBUTORY Myocardial Insufficiency.  
(Secondary)

(duration) . . . . yrs. . . . mos. . . . ds

18 Where was disease contracted  
if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? .....

Was there an autopsy? ☒ Yes ☐ No

What test confirmed diagnosis? Clinical Diagnosis.

(Signed) M M Heinsdorf ..... M. D.

8/28 1922 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20. UNDERTAKER

19 PLACE OF BURIAL, CREMATION OR RE  
2 REMOVAL  
Holy Cross Cem. B. F. Co. Mar 31 1922

Filed  
MAR 30 1972

Burial Permit Clerk.



D 62984

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 62984

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 E 22nd ST. 9 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Ellen Prenger

## (a) RESIDENCE NO.

717 E 22nd  
(Usual place of abode)  
Length of residence in city or town where death occurred 56 yrs. mos.

## ST. WARD

(If non-resident give city or town and State)  
ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) widowed5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of ✓6 DATE OF BIRTH (month, day, and year) Nov-27-18547 AGE Years 68 Months 4 Days 1 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland  
(State or country)10 NAME OF FATHER Patrick Brennan11 BIRTHPLACE OF FATHER (city or town) Ireland  
(State or country)12 MAIDEN NAME OF MOTHER Margaret Fitzgerald13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)14 Informant Mary Prenger  
(Address) 717 E 22nd St15 Robert F. Harrison,  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 192217 I HEREBY CERTIFY. That I attended deceased from Oct 1, 1921, to Mar 28, 1922, that I last saw him alive on March 27, 1922, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of LiverCONTRIBUTORY (Secondary) Bronchial Pneumonia  
(duration) yrs. 6 mos. ds.18 Where was disease contracted if not at place of death? 717 E 22nd StDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) James M. Fulton, M. D.  
Address 700 E Chase St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL Cathedral Camp DATE OF BURIAL March 19 22

20 UNDERTAKER

Margaret G. Flynn ADDRESS undisclosed

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MAR 30 1922

Burial Permit Clerk.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62985

## CERTIFICATE OF DEATH.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 W Fayette ST.; 19 WARD)

2-FULL NAME Anna Provenza

(Residence in Baltimore: No. 1613 W Fayette St.; yrs. 4 mos. 5 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F 4-COLOR OR RACE, W 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, S (Write the word.)

6-DATE OF BIRTH, 11-25-1921 (Month) (Day) (Year)

7-AGE, 4 yrs. 5 mos. 5 ds. 12 LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), City

10-NAME OF FATHER, Vincent Provenza

11-BIRTHPLACE OF FATHER, Italy -

12-MAIDEN NAME OF MOTHER, Rosa Cimino

13-BIRTHPLACE OF MOTHER, Italy -

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rosa Provenza

(Address) 1613 W Fayette St.

15-

Robert P. Harrison,

191

Registrar.

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3-29-1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3-27-1922 to 3-29-1922, that I saw her alive on 3-28-1922, and that death occurred, on the date stated above, at 10, m. The CAUSE OF DEATH\* was as follows:

Polar pneumonia (Duration) yrs. mos. 2 ds.

CONTRIBUTORY Polar pneumonia (Secondary) (Duration) yrs. mos. 2 ds.

(Signed) S. J. Harrison M. D. 3-30-1922 (Address) 1613 W Fayette St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

New Cathedral Mar 31, 1922

20-UNDERTAKER

ADDRESS

George Schwab 201 E. Baltimore Ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

D 62986 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62986

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 15)

2-FULL NAME

(Residence in Baltimore: No. 1623 Thomas St.)

REGISTERED No. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Life St.; yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH,

7-AGE,

IF LESS than 1 day, ...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

ID1

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Pneumonia - lobar by  
Cerebral (Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.  
(Signed) J. H. Miller, M. D.  
(Coroner)

3-36 1922 (Address) 1710 E. St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. mos. da. State... yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 30 1922

D 62987

## HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 62987

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 836 Mangold ST.: 21 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

James Isaac Buck

## (a) RESIDENCE. NO.

836 Mangold ST.

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

75 yrs. 3 mos. 2 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Dec. 5, 1846

## 7 AGE

75325

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

Commissioner

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

## 10 NAME OF FATHER

Joseph A. Buck

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Harriet Grist

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Penn.

## 14

Informant (Address)

George A. Buck  
836 Mangold St.

## 15

Filed

Robert P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1922

17

I HEREBY CERTIFY, That I attended deceased from March 27, 1922, to March 30, 1922.that I last saw him alive on March 29, 1922.and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart Disease

(duration) ? yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Cardiac Decompensation(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

Clinical findings

(Signed)

John A. Buchness, M. D.

19 (Address)

650 Washington Blvd.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Baltimore CemeteryMar 31 1922

## 20 UNDERTAKER

## ADDRESS

John F. Denny715 L St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

MAR 30 1922

Burial Permit Clerk



WRITE PLAINLY, WITH CORRECTION. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62988 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62988  
CERTIFICATE OF DEATH.

1-PLACE OF DEATH  
CITY OF BALTIMORE (No. 836 Mangold St.  
2-FULL NAME Evelyn Brock  
(Residence in Baltimore: No. 836 Mangold St.  
REGISTERED NO. C  
ST. 71 WARD (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female	4-COLOR OR RACE, White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
6-DATE OF BIRTH, Not known, 1		
7-AGE, 71 yrs. mos. da. If LESS than 1 day, hrs. or min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Housework		
9-BIRTHPLACE, (State or Country), Baltimore City		
PATIENTS.	10-NAME OF FATHER, Joseph A Brock	
	11-BIRTHPLACE OF FATHER, (State or Country), Baltimore City	
	12-MAIDEN NAME OF MOTHER, Harris	
	13-BIRTHPLACE OF MOTHER, (State or Country), Pa	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) George Brock  
(Address) 836 Mangold St.

15- Robert P. Harrison, 191, Registrar.  
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,  
31, 28, 1912.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to his death on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
Valvular disease of the heart  
(Duration) Not known  
CONTRIBUTORY (Secondary) Not known  
(Duration) Not known  
(Signed) H. J. Foxworth, M. D. (Coroner.)  
31.30., 1922 (Address) 117 N. Saratoga St.  
\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).  
At place of death... yrs. mos. da. In the State... yrs. mos. da.  
Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery	DATE OF BURIAL, Mar. 31 1922
20-UNDERTAKER, John F. Denny	ADDRESS, 715 Light

MAR 30 1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62989

D 62989

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Orlando Ave* ST., *129* WARD)

## 2. FULL NAME

*Henry Wildberger*

## (a) RESIDENCE NO.

*Orlando Ave*

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *50* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Jan 23 - 1851*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*71**2**6*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Blksmith, Retired*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)*9 years*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Md.*

10 NAME OF FATHER

*Henry Wildberger*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Switzerland*

12 MAIDEN NAME OF MOTHER

*Franz Baedler*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Switzerland*

14

Informant  
(Address)*Mr. W. Wildberger  
Orlando Ave*

15

*Robert P. Harrison,*

Registrar

Burial Permit Clerk.

## REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 29, 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan. 24, 1922* to *March 29, 1922*  
that I last saw him on *March 29, 1922*and that death occurred, on the date stated above, at *10.10 a.m.*

The CAUSE OF DEATH\* was as follows:

*Chr. interstitial nephritis*(duration) *9* yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*A. M. Bacon* M. D.

19

(Address)

*Parkville, Md.*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL

*St. John's Cemetery* *3/31/ 1922*

20 UNDER TAKER

ADDRESS

*Wm Cook, 502 E North ave.*B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state  
cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPA-  
TION is very important. See instructions on back of certificates.

MAR 30 1922

WRITE PLAINLY, WITH CAPITAL LETTERS. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62990

CERTIFICATE OF DEATH.

D 62990

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *W. P. J.* ST. *14* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Laurence A. Gisriel*

(Residence in Baltimore: No. *1434 John St.*)

St. *13* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)

6-DATE OF BIRTH, *1909* (Month) (Day) (Year)

7-AGE, *13* yrs. mos. ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *none* (b) General nature of industry, business, or establishment in which employed (or employer), *000*

9-BIRTHPLACE, (State or Country), *Baltimore City*

10-NAME OF FATHER, *Joseph Gisriel*

11-BIRTHPLACE OF FATHER (State or Country), *Balto*

12-MAIDEN NAME OF MOTHER, *Frances Mooney*

13-BIRTHPLACE OF MOTHER (State or Country), *Balto*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Jos Gisriel*

(Address) *1436 John St*

15-ROBERT R. KRAUTER,

MAR 31 1922 191. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *March 28*, 19*22* (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the *day* stated above. The CAUSE OF DEATH\* was as follows:

*Stroke on accident*  
*amputation of right leg*  
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) *J. C. J. Hennessy* M. D. (Coroner.) *March 31, 1922* (Address) *2712 E. Frederick St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place *W. P. J.* In the of death, yrs. mos. ds. State, yrs. mos. ds.

Where was disease contracted, if not at place of death? *German & Mordecai*

Former or usual residence *1434 John St*

19-PLACE OF BURIAL OR REMOVAL, *Cathedral* DATE OF BURIAL, *March 30, 1922*

20-UNDERTAKER, *Martin Schep* ADDRESS *1827 W North Ave*

D 62991 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Greenway Apts. 341 1/2 Charles St.*)ST.: *1* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. *Greenway Apts.*

(Usual place of abode)

ST.: *1*

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *2* yrs. *2* mos. *—* ds. How long in U. S., if of foreign birth? *—* yrs. *—* mos. *—* ds.

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of *J. Ward Allison*  
(or) WIFE of6 DATE OF BIRTH month, day, and year *Sept 25, 1878*

7 AGE

Years *43*Months *6*Days *51*

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*(b) General nature of industry, business, or establishment in which employed (or employer) *— 037*(c) Name of employer *—*9 BIRTHPLACE (city or town) *Indianapolis*  
(State or country)10 NAME OF FATHER *Richard Wolfe*11 BIRTHPLACE OF FATHER (city or town) *Ireland*  
(State or country)12 MAIDEN NAME OF MOTHER *Mary E. Fogarty*13 BIRTHPLACE OF MOTHER (city or town) *Mass*  
(State or country)

14

Informant *J. Ward Allison*  
(Address) *Greenway Apts.*

15

Filed

19

MAR 31 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 30 1922*17 I HEREBY CERTIFY, That I attended deceased from *Feb 15, 1922* to *Mar 30, 1922*that I last saw him alive on *Mar 30, 1922*and that death occurred, on the date stated above, at *4:15 p.m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Heart Disease*  
*Endocarditis & Myocarditis*  
(duration) *2* yrs. *—* mos. *—* ds.

CONTRIBUTORY (Secondary)

(duration) *—* yrs. *—* mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical Exam*(Signed) *Walter Thomas* M. D.Address *428 1/2 Cas line*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Chicago Ill. March 31 1922*

20 UNDERTAKER

*Robert S. Little* ADDRESS *2100 Edmondson*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

62992

D 62992

## CERTIFICATE OF DEATH.

REGISTERED No. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *134 W. Astend*)ST. *23* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *134 W. Astend*)

St.; yrs. mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Female*

## 4-COLOR OR RACE,

*White*5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)  
*Married*

## 6-DATE OF BIRTH,

*March**1<sup>st</sup>**1870*

(Month)

(Day)

(Year)

## 7-AGE,

*52*

yrs.

*0*

mos.

*29*

da.

If LESS than 1 day,

....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

*House work*

(b) General nature of industry, business, or establishment in which employed (or employer).

*037*9-BIRTHPLACE,  
(State or Country),*Baltimore Md*

## 10-NAME OF FATHER,

*Lewis H. Heister*11-BIRTHPLACE OF FATHER  
(State or Country),*Balto Md*

## 12-MAIDEN NAME OF MOTHER

*Anna Struckman*13-BIRTHPLACE OF MOTHER  
(State or Country),*Balto Md*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Baldwin Hick*

(Address)

*134 W. Astend St*

## 15-

MAR 31 1922

ROBERT R. KRAUTER,

Filed

191

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*March**20**1922*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *March 25* 1922, to *March 30* 1922, that I saw her alive on *March 27* 1922, and that death occurred, on the date stated above, at *6:30* A.M.

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*

(Duration).....yrs.....mos.....da.

CONTRIBUTORY  
(Secondary)

(Duration).....yrs.....mos.....da.

(Signed)

*John P. Bishop*

M. D.

*March 31, 1922* (Address) *730 N. Calvert St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*London Park Cem**April 1, 1922*

## 20-UNDERTAKER

ADDRESS *1039**E. Schloman Son**Harmon St*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62993

62993

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1601 Milliman St. ST.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie Hainwright(Residence in Baltimore: No. 1601 Milliman St. St.; 7 yrs. 1 mos. 14 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored5-SINGLE,  
MARRIED,  
WIDOWED,  
OR-DIVORCED.  
(Write the word.)  
Married

6-DATE OF BIRTH

February 14 1878  
(Month) (Day) (Year)

7-AGE,

44 yrs. 1 mos. 14 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housework  
0379-BIRTHPLACE,  
(State or Country),Maryland10-NAME OF  
FATHER,North Hallowood11-BIRTHPLACE  
OF FATHER  
(State or Country),Maryland12-MAIDEN NAME  
OF MOTHERElizabeth Snelton13-BIRTHPLACE  
OF MOTHER  
(State or Country),Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Hainwright  
(Address) 1601 Milliman St.

15-

MAR 3 1 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 28, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from  
March 25, 1922, to March 28, 1922,  
that I saw her alive on March 28, 1922,  
and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....arterio-sclerosis.....  
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Richard C. Casper M. D.March 29, 1922 (Address) 1574 S. Baltimore

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Evergreen Cem

DATE OF BURIAL,

April 1, 1922

ADDRESS

1302 Jefferson

20-UNDERTAKER

Mrs. J. Locks

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62994

## CERTIFICATE OF DEATH.

REGISTERED No. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Carey ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 4125 Carey St. St.; 68 yrs., 3 mos., 4 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH Dec 26, 1853  
(Month) (Day) (Year)

7-AGE, 68 yrs., 3 mos., 4 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work H. W. J.  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

10-NAME OF FATHER, Robert Hunter

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Susana Starr

13-BIRTHPLACE OF MOTHER (State or Country), Balto

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Hunter(Address) 1125 Carey St.

15 **MAR 31 1922** **ROBERT R. KRAUTER,**  
Filed 191

Burial Permit 6106

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 30, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1922 to Mar 30 1922 that I saw her alive on Mar 28 1922 and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH\* was as follows:  
Acute Bright's Disease  
(Duration) 3 yrs., 3 mos., 4 ds.

CONTRIBUTORY (Secondary) Nephritis  
(Duration) 3 yrs., 3 mos., 4 ds.

(Signed) John E. Jones M. D.  
Mar 30 1922 (Address) 1520 Hollman St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAVELERS, OR RECENT RESIDENTS).

At place of death 3 yrs., 3 mos., 4 ds. In the State 3 yrs., 3 mos., 4 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, National Cemetery DATE OF BURIAL, Mar 31, 1922

20-UNDERTAKER, John Fields 1200 N. Lombard ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 62995

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1121 W. Mulberry

ST. 18 WARD)

## 2-FULL NAME Joseph Rhodes

(a) RESIDENCE. No. 1121 W. Mulberry

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 10 mos. 17 ds. How long in U. S., if of foreign birth? 75 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Josephine L Rhodes

6 DATE OF BIRTH (month, day, and year)

May 12 1846

7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

75

10

17

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

Poultry

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md.

10 NAME OF FATHER

John R Rhodes

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md.

12 MAIDEN NAME OF MOTHER

Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md.

14

Informant (Address)

Mrs Josephine L Rhodes

ROBERT R. KRAUTER,

15

MAR 31 1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1922

17 I HEREBY CERTIFY, That I attended deceased from

March 22, 1922, to March 29, 1922,

that I last saw him alive on March 28, 1922,

and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH\* was as follows:

Arterio-sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

3/30, 1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt Olivet

DATE OF BURIAL

April 1 1922

20 UNDERTAKER

W M Roulston

ADDRESS

2238 W. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—PHYSICIANS should state EXACTLY. Exact statement of OCCUR-  
rence should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUR-  
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No hemorrhage  
Not apoplectic*

D 62996

## HEALTH DEPARTMENT—CITY OF BALTIMORE

62996

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 Mulberry St.)ST., 17 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Lewis Eugene St Meyer

## (a) RESIDENCE NO.

506 Mulberry

ST., \_\_\_\_\_ WARD \_\_\_\_\_

(If non-resident give city or town and State)

(Usual place of abode)  
Length of residence in city or town where death occurred 63 yrs. 0 mos. 3 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofEmma Weathers St Meyer

6 DATE OF BIRTH (month, day, and year)

March 25 1859

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.6303

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Balto Md.

10 NAME OF FATHER

John St Meyer11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Md.

12 MAIDEN NAME OF MOTHER

Emma Tracy13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Pa.

14

Informant  
(Address)Mrs Emma St Meyer  
506 W Mulberry St

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1922

17

I HEREBY CERTIFY, That I attended deceased from

April 1920, to Feb 28 1922.that I last saw him alive on Feb 28 1922.and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH\* was as follows:

ArteriosclerosisCONTRIBUTORY  
(Secondary)(duration) 2 yrs. 0 mos. 0 ds.Coronary Atherosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? 506 Mulberry StDid an operation precede death? No Date of \_\_\_\_\_Was there an autopsy? NoWhat test confirmed diagnosis? Chinap

(Signed)

(Address)

Chinap  
1205 S. W. St.  
Arlington

State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

Woodlawn Cemetery  
W M Rouse

DATE OF BURIAL

March 31 1922

ADDRESS

223 S W  
Mt Air

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state Exact statement of OCCUPATION. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62997 HEALTH DEPARTMENT—CITY OF BALTIMORE D 62997

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2054 Mount St. 14 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1832 Elting St.; yrs. 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, Colored 5-Single, Married, Widowed, or Divorced, Married (Write the word.)

6-DATE OF BIRTH, May 4, 1893 (Month) (Day) (Year)

7-AGE, 28 yrs. 10 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, House work (b) General nature of industry, business, or establishment in which employed (or employer), at home

9-BIRTHPLACE, (State or Country), Virginia

10-NAME OF FATHER, Richard Parham

11-BIRTHPLACE OF FATHER, (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Sarah Walker

13-BIRTHPLACE OF MOTHER, (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Namie Parham

(Address), 1832 Elting St

15- MAR 31 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 28, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Peritonitis and pneumonia

(Duration), 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration), 1 yrs. mos. ds.

(Signed), J. M. D.

(Address), 1008 Chase

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

1822 Elting St

Former or usual residence, 1422 Elting St

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

At Ashbur Mar 31, 1922

20-UNDERTAKER, ADDRESS, 114 W

Brown, Freda. Schuch

D 62998

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 62998

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 343/Leaverton ST., 76 WARD)

## 2-FULL NAME Catherine Staib

(a) RESIDENCE NO. 343/Leaverton

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

MAR 31 1922

ROBERT R. KRAUTER,

Bureau Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

HEREBY CERTIFY, That I attended deceased from

March 2, 1922, to March 27, 1922, that I last saw her alive on

and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH\* was as follows:

Grippe - Acute Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

March 29, 1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Western Cemetery

20 UNDERTAKER

John Henry &amp; Co

DATE OF BURIAL

Mar 31 1922

ADDRESS

2008 Calverton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 62999

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

177 D 62999

PLACE OF DEATH

CITY OF BALTIMORE (Name of Hospital)

FULL NAME

(Residence in Baltimore: No. 1411 Cooksey St.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, 1877 (Month) (Day) (Year)

7-AGE, 45 yrs., mos., ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). (Address).

15- MAR 31 1922 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 29, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows: Brawl with Henry Perry (Duration) yrs., mos., ds.

CONTRIBUTORY (Secondary) Accidentally Taken (Duration) yrs., mos., ds.

(Signed) M. D. (Coroner.) 3:30, 1922 (Address) 117 W. Saratoga St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill DATE OF BURIAL, April 1, 1922

20-UNDERTAKER, Robt J. Turner Inc. ADDRESS 1442 W Broadway

**N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.** Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63000

75-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(2) RESIDENCE No 1828 Bolton ST., WARD

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1922

17 I HEREBY CERTIFY, That I attended deceased from  
March 21, 1922, to March 24, 1922.

that I last saw her alive on Mon, 28, 1922.

and that death occurred, on the date stated above, at 8<sup>30</sup> a.m.

The CAUSE OF DEATH\* was as follows:

Hemiplegia Right - 1st

(duration) yrs. mos. 6, da

**CONTRIBUTORY**  
(Secondary)

(duration) . . . yrs. . . . mos. . . . ds

18 Where was disease contracted  
if not at place of death?.....

Did an operation precede death?.....Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) \_\_\_\_\_, M. D.

4-30-1922 (Address) Latrobe City, Pa.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

## 20 UNDERTAKER

ADDRESS

MAR 31 1922

ROBERT R. KRAUTER  
Burial Permit Clerk

N. Vanderly 17109

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-11 H. B. C. 1000 Rks.

D 63001

HEALTH DEPARTMENT—CITY OF BALTIMORE D 63001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

Mercy Hospital

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs Anna Kyles

(a) RESIDENCE. NO.

Grostburg Ind.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Yrs.

mos.

10

ds.

How long in U. S., if of foreign birth?

Yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John Kyles

6 DATE OF BIRTH (month, day, and year)

Dec. 2, 1879

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

42

3

28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

007

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ind.

10 NAME OF FATHER

George Esrable

11 BIRTHPLACE OF FATHER (city or town) (State or country)

?

12 MAIDEN NAME OF MOTHER

Helen -

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

?

14

Informant (Address)

Mercy Hospital Records.

15

MAR 31 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 30, 1922

17

I HEREBY CERTIFY, That I attended deceased from March 20, 1922, to March 30, 1922

that I last saw her alive on March 30, 1922.

and that death occurred, on the date stated above, at 7:55 P. M.

The CAUSE OF DEATH\* was as follows:

Acute Pancreatitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Exposure to shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Legionnaires

Did an operation precede death?

Yes Date of Mar. 30, 1922

Was there an autopsy?

No

What test confirmed diagnosis?

Findings, Signs & Symptoms

(Signed)

John J. Cravie M. D.

, 19

Address Mercy Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cumberland, Md.

3-31 1922

20 UNDERTAKER

ADDRESS

James Dignan & Son

Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Rls.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63002

## CERTIFICATE OF DEATH.

101-001 D 63002

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 Columbia Ave. ST. 21 WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

Della W. Kuhl

(a) RESIDENCE NO. 820 Columbia Ave. ST. 21 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 8<sup>th</sup> 1872

7 AGE Years 49 Months 9 Days 22 If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER Jackson Fountain

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant George E. Kuhl Sr. (Address) 820 Columbia Ave.

15 ROBERT R. KRAUTER Registrar

MAR 31 1922

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 30<sup>th</sup> 1922

17 I HEREBY CERTIFY, That I attended deceased from 3/29/22, 1922 to 3/30/22, 1922

that I last saw her alive on 3/29/22, 1922

and that death occurred, on the date stated above, at 1:55 A. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) 4 1/2 yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Smear

(Signed) Bernard J. Levy, M. D.

(Address) 90 W. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR RE-MOVAL

Landon Park Cem. Mar. 1922

20 UNDERTAKER

Joseph B. Cook ADDRESS 1003 N. Belts



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63003

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 63003

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Md. Gen Hosp.* ST., *15* WARD)

REGISTERED NO:

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Chas E Buck* (*Charles Edward Buck*)

(a) RESIDENCE NO. *3500 Park Heights Ave.* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *30* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *—*

6 DATE OF BIRTH (month, day, and year) *Mar. 15<sup>th</sup> 1865*

7 AGE Years *57* Months *0* Days *14* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Merchant (Lumber)*

(b) General nature of industry, business, or establishment in which employed (or employer) *Hebberd Lumber Co.*

(c) Name of employer

9 BIRTHPLACE (city or town) *Williamsport* (State or country) *Pa*

10 NAME OF FATHER *John W Buck*

11 BIRTHPLACE OF FATHER (city or town) *Muncy* (State or country) *Pa*

12 MAIDEN NAME OF MOTHER *Mary Thomas*

13 BIRTHPLACE OF MOTHER (city or town) *Pa* (State or country)

14 Informant *Hiram M. Buck* (Address) *30 Church St. New York*

15 *ROBERT R. KRAUTER* Registrar *MAR 31 1922* Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/29/22*

17 I HEREBY CERTIFY, That I attended deceased from *2/3/22*, 19*22*, to *3/29/22*, 19*22*.

that I last saw him alive on *3/29/22*, 19*22*.

and that death occurred, on the date stated above, at *10<sup>20</sup> P. M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Atrophic Nephritis*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Acute Arterial Pth*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *✓*

Did an operation precede death? *✓* Date of

Was there an autopsy? *✓*

What test confirmed diagnosis? *Chemical & graph*

(Signed) *John A. Thompson* M. D.

*Mar. 30* (Address) *Williamsport, Pa.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL

*Williamsport Pa* *April 1<sup>st</sup> 22*

20 UNDERTAKER ADDRESS

*Joseph B. Cook* *1013 N. Datto St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

D 63004

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *644 N. Hoffman* ST.; *17* WARD)2-FULL NAME *Mary E. Hoffmann*(Residence in Baltimore: No. *644 N. Hoffman* St.; *16* yrs., *16* mos., *16* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE. *Poland* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married* (Write the word.)6-DATE OF BIRTH. *March 20, 1902* (Month) (Day) (Year)7-AGE. *20* yrs., *16* mos., *16* ds. If LESS than 1 day, .... hrs. or .... min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Homemaker* (b) General nature of industry, business, or establishment in which employed (or employer). *031*9-BIRTHPLACE, (State or Country). *md.*10-NAME OF FATHER. *John Clash*11-BIRTHPLACE OF FATHER, (State or Country). *md.*12-MAIDEN NAME OF MOTHER. *Dusan Clash*13-BIRTHPLACE OF MOTHER, (State or Country). *md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Dusan Clash*(Address) *644 N. Hoffman*

15-

Filed..... 191.. *ROBERT R. KRAUTER* Registrar.

MAR 31 1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *3-24-1922* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *March 20, 1922*, to *March 22, 1922*, that I saw her alive on *March 22, 1922*, and that death occurred, on the date stated above, at *2:10 a.m.* The CAUSE OF DEATH\* was as follows:*Pulmonary Tuberculosis* (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)..... (Duration)..... yrs..... mos..... ds.

(Signed) *Jas. A. Quinn* M. D.*2-20-1922* (Address) *1063 Myrtle Ave.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Cambridge Md.* DATE OF BURIAL, *3/31, 1922*20-UNDERTAKER, *Samuel T. Henry* ADDRESS *578 W. 34th St.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63005		1000 Bks.		HEALTH DEPARTMENT—CITY OF BALTIMORE		D 63005	
CERTIFICATE OF DEATH.							
1-PLACE OF DEATH				REGISTERED NO.			
CITY OF BALTIMORE: (No. <u>530 Burgundy Alley</u> ST. <u>27</u> WARD)				(If death occurred in a hospital or institution, give its NAME instead of street and number.)			
2-FULL NAME <u>Annie Cornish</u>							
(a) RESIDENCE. NO. <u>530 Burgundy Alley</u> ST. <u>27</u> WARD.				(If nonresident give city or town and State)			
(Usual place of abode)				(If nonresident give city or town and State)			
Length of residence in city or town where death occurred				How long in U. S., if of foreign birth?			
yrs. mos. ds.				yrs. mos. ds.			
PERSONAL AND STATISTICAL PARTICULARS							
3 SEX <u>Female</u>		4 COLOR OR RACE <u>Colored</u>		5 Single, Married, Widowed, or Divorced (write the word) <u>Widow</u>			
5a If married, widowed, or divorced							
HUSBAND of (or) WIFE of <u>Unknown</u>							
6 DATE OF BIRTH (month, day, and year) <u>1853</u>							
7 AGE		Years		Months		Days	
<u>69</u>						If LESS than 1 day, hrs. or min.	
8 OCCUPATION OF DECEASED							
(a) Trade, profession or particular kind of work <u>None</u>							
(b) General nature of industry, business, or establishment in which employed (or employer)							
(c) Name of employer							
9 BIRTHPLACE (city or town) (State or country) <u>Baltimore Md</u>							
10 NAME OF FATHER <u>Jacob Gibson</u>							
11 BIRTHPLACE OF FATHER (city or town) (State or country) <u>Md</u>							
12 MAIDEN NAME OF MOTHER <u>Hannah Mosell</u>							
13 BIRTHPLACE OF MOTHER (city or town) (State or country) <u>Md</u>							
14 Informant <u>Carrie Greene</u> (Address) <u>530 Burgundy Alley</u>							
15 File <u>MAR 31 1922</u> <u>ROBERT R. KRAUTER</u> Registrar							
MEDICAL CERTIFICATE OF DEATH							
16 DATE OF DEATH (month, day, and year) <u>Mar 28</u> 19 <u>22</u>							
17 I HEREBY CERTIFY, That I attended deceased from <u>March 21</u> 19 <u>22</u> , to <u>March 28</u> 19 <u>22</u> , that I last saw him alive on <u>March 28</u> 19 <u>22</u> , and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Apoplexy Cerebral Hemiplegia</u>							
CONTRIBUTORY (Secondary) <u>Ca Hemiplegia</u> (duration) yrs. mos. 7 ds.							
18 Where was disease contracted <u>Home</u> If not at place of death? <u>Yes</u> Date of <u>March 28</u> 19 <u>22</u>							
Did an operation precede death? <u>No</u> Was there an autopsy? <u>No</u>							
What test confirmed diagnosis <u>Microscopic</u> (Signed) <u>Dr. H. H. H.</u> M. D.							
*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)							
19 PLACE OF BURIAL, CREMATION OR REMOVAL <u>St. Ambrose</u>				DATE OF BURIAL <u>3/31</u> 19 <u>22</u>			
20 UNDERTAKER <u>Samuel H. H.</u>				ADDRESS <u>57800 Biddle</u>			

MARGIN RESERVED FOR PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

63006

HEALTH DEPARTMENT—CITY OF BALTIMORE D 63006

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 Redwood ST., WARD)

2-FULL NAME

(a) RESIDENCE. No. 715 Redwood ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of Ollie Davis

6 DATE OF BIRTH (month, day, and year) Oct 81 1880

7 AGE 42 Years 1 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stereore

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) N.C. (State or country) Wayne County

10 NAME OF FATHER Jim Davis

11 BIRTHPLACE OF FATHER (city or town) N.C. (State or country)

12 MAIDEN NAME OF MOTHER Hutter George

13 BIRTHPLACE OF MOTHER (city or town) N.C. (State or country)

14 Informant Mrs. Ollie Davis 715 Redwood St.

15 MAR 31 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 19 1922 to Mar 28 1922 that I last saw him alive on Mar 27 1922.

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH\* was as follows:

Supper over

CONTRIBUTORY (Secondary) (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? 41

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Morley H. Hogg M. D.

Address 729 Columbia

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

West Auburn Cemetery 3/31 1922

20 UNDERTAKER Mrs. G. H. Hogg 408 N. E. St.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Probably tuberculous*

WRITE EXACTLY, WITH CARE. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D 63007

CERTIFICATE OF DEATH.

100-00 D 63007  
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 837 Clifford ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Summa Fletcher  
(Residence in Baltimore: No. 837 Clifford St.; 48 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F 4-COLOR OR RACE. Col 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) widow

6-DATE OF BIRTH. 1874 (Month) (Day) (Year)

7-AGE. 48 yrs., mos. ds. If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Wash & Iron (b) General nature of industry, business, or establishment in which employed (or employer). 041

9-BIRTHPLACE, (State or Country), Ind

10-NAME OF FATHER, Joe Franklin

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Mary Matthews

13-BIRTHPLACE OF MOTHER (State or Country), Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 916 Pa ave

15- MAR 31 1922 ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 29, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3-27 1922, to 3-29 1922, that I saw her alive on 3-28 1922, and that death occurred, on the date stated above, at m. The CAUSE OF DEATH\* was as follows: Bronchi Pneumonia

(Duration)....yrs....mos....16....ds.

CONTRIBUTORY.....cardiac insufficiency (Secondary)

(Duration)....yrs....mos....ds.

(Signed) Thos B Hall M. D.

....., 191... (Address) Halesboro

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Mt Auburn Burial 2, 1922

20-UNDERTAKER Daniel Easton ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bka.

D 63008

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63008

159-000

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 N. Eden ST. 10 WARD)

2-FULL NAME

Baby Smallwood

(a) RESIDENCE. NO. 809 N. Eden

ST. WARD.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(Usual place of abode) Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-28-22

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER John Smallwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lady Wilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Daniel Bowers (Address) 809 N. Eden St

15 MAR 31 1922 ROBERT A. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-30-1922

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1922, to March 29, 1922, that I last saw him alive on March 29, 1922, and that death occurred, on the date stated above, at 6:30 a. m. The CAUSE OF DEATH\* was as follows:

Malformation of liver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? W Date of

Was there an autopsy? W

What test confirmed diagnosis? Enlarged liver

(Signed) A. L. Hornstein M. D.

3/30, 1922 (Address) 733 Argyle St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Wesleyan Bur March 31 1922

20 UNDERTAKER ADDRESS 906

David Easton

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63009

## CERTIFICATE OF DEATH.

100-101 63009

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2013 Spruce

ST. 2 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Korpisz

(a) RESIDENCE. NO. 2013 Spruce

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sep 11 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

6

19

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Charles Korpisz

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Helen Wisniewski

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Charles Korpisz 2013 Spruce St

15

Filed

19

ROBERT P. KAUFER Registrar

MAR 31 1922

Burial Permit Clerk.

20

UNDERTAKER

John Matcher

1803 Bank

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary

March 31 1922

20

UNDERTAKER

John Matcher

1803 Bank

16 DATE OF DEATH (month, day, and year)

March 30 1922

17

I HEREBY CERTIFY, That I attended deceased from March 10<sup>th</sup> 1922, to March 29, 1922, that I last saw him alive on March 29, 1922,

and that death occurred, on the date stated above, at 1215 P. M.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sig. no. 1000000000

(Signed) Harry M. Kaufman M. D.

19 (Address) 2023 Callow Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 63010

PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 15 ST. 15 WARD)

2-FULL NAME *Wendel Perry*

(a) RESIDENCE NO. *1315 N. Mount St.* ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Black* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug 1921*

7 AGE Years *7* Months Days If LESS than 1 day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore*

10 NAME OF FATHER *Willis Perry*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *S.C.*

12 MAIDEN NAME OF MOTHER *Emie Gattalano*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *S.C.*

14 Informant *JOHNS HOPKINS HOSPITAL* (Address) *Account*

15 Registrar *GL* File *MAR 31 1922*

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 24<sup>th</sup> 1922*

17 I HEREBY CERTIFY, That I attended deceased from *March 24<sup>th</sup> 1922* to *March 28 1922*, that I last saw him alive on *March 28 1922*, and that death occurred, on the date stated above, at *11 4 m.*

The CAUSE OF DEATH\* was as follows: *Acute generalized military tuberculosis*

CONTRIBUTORY (Secondary) *Tuberculosis meningitis* (duration) yrs. *2* mos. — ds.

(duration) yrs. mos. *7* ds.

18 Where was disease contracted if not at place of death? *Home*

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *X-Ray lumbar puncture*

(Signed) *Horace G. Stewart*, M. D.

*329 19<sup>th</sup>* (Address) *Johns Hopkins Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS *303*

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Lungs involved*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rhs.

*Freemantle Zaccaria* ✓  
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63011

CERTIFICATE OF DEATH.

159-000 D 63011  
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *404 S. High St.* ST. *3* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Freemantle Zaccaria*

(a) RESIDENCE NO. *404 S. High St.* ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

ys.

mos.

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Infant*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Infant*

6 DATE OF BIRTH (month, day, and year) *March 14, 1922*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *17*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Infant*

(b) General nature of industry, business, or establishment in which employed (or employer) *000*

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*  
(State or country) *Maryland*

10 NAME OF FATHER *Nick Zaccaria*

11 BIRTHPLACE OF FATHER (city or town) *Italy*  
(State or country)

12 MAIDEN NAME OF MOTHER *Maria Zambetti*

13 BIRTHPLACE OF MOTHER (city or town) *Italy*  
(State or country)

14 Informant *Victoria Cardina*  
(Address) *404 S. High St.*

15 Filed *MAR 31 1922* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 30 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Mar 25, 1922* to *Mar 30, 1922*, that I last saw him alive on *Mar 30, 1922*, and that death occurred, on the date stated above, at *8:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Congenital Cardiac*  
*muscle*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. J. [Signature]* M. D.

(Address) *1212 [Address]*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Wendell [Signature]*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63012

## CERTIFICATE OF DEATH.

179 D 63012

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 S. StrickerST. 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C. Tudor(Residence in Baltimore: No. 111 S. StrickerSt. 25 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH.

August 23, 1848  
(Month) (Day) (Year)

7-AGE.

73 yrs. 7 mos. 6 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Machinist 031

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Henry C. Tudor

11-BIRTHPLACE OF FATHER (State or Country),

England

12-MAIDEN NAME OF MOTHER

Martha Crawford

13-BIRTHPLACE OF MOTHER (State or Country),

Anne

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret A. Tudor(Address) 111 S. Stricker

15-MAR 31 1922

ROBERT R. KRAUTER,

191. Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 29, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Mch 12, 1922, to Mch 29, 1922that I saw him alive on Mch 28, 1922and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH\* was as follows:

Uremia

(Duration) yrs. mos. ds.

CONTRIBUTORY C. pneumoniae H. influenza  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. B. Green and L. H. Smith M. D.Mch 29, 1922 (Address) 626 N. Johnson St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Greenmount Cemetery

DATE OF BURIAL.

20-UNDERTAKER

George J. SmithADDRESS 1000 Fayette StWRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63013

## CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1732 Thames Street

ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abraham Adleberg

(Residence in Baltimore: No. 1732 Thames Street

40  
St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, 1 857  
(Month) (Day) (Year)

7-AGE, 65 If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, Merchant  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Russia

10-NAME OF FATHER, Hirsh Adleberg

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Esther

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) J. Lewis

(Address) 1439 B. Balto St.,

15- ROBERT R. KRAUTER,  
MAR 31 1922 191. Burial Permit

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 30, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Myocardial degeneration  
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) M. D. Mar 31 1922 (Address) 1439 B. Balto St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, 31 31 1922

20-UNDERTAKER, Jack Lewis 1439 B. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63014 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1712 E. Eager ST., 7 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

38 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

38 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Andrew Laeblein

6 DATE OF BIRTH (month, day, and year)

Sept. 6, 1855

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

66

6

15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

John Muhel

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Catherine Engel

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Andrew Laeblein 1712 E. Eager St.

15

MAR 31 1922

ROBERT H. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 31 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 27, 1922, to March 31, 1922,

that I last saw her alive on March 31, 1922,

and that death occurred, on the date stated above, at 4 A. M.

The CAUSE OF DEATH\* was as follows:

Arterial Sclerosis, Chronic Nephritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Gustav Klement, M. D.

March 31, 1922 (Address) 928 E. Camden

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Redeemer

April 3, 1922

20 UNDERTAKER

ADDRESS

Fritsker & Fritsker

Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63015

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1923 D and Hill Ave ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Amelia E. Johnson*

(a) RESIDENCE. NO. 1923 D and Hill Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F* 4 COLOR OR RACE *C* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced *HUSBAND of Harvey Johnson* (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Jan 14, 1858*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *64 2 15*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Toronto Canada* (State or country)

10 NAME OF FATHER *unknown*

11 BIRTHPLACE OF FATHER (city or town) *unknown* (State or country)

12 MAIDEN NAME OF MOTHER *unknown*

13 BIRTHPLACE OF MOTHER (city or town) *unknown* (State or country)

14 Informant *Harvey Johnson* (Address) *1923 D and Hill Ave*

15 Filed *19* *ROBERT R. KRAUTER* Registrar

MAR 31 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 29 1922*

17 I HEREBY CERTIFY, That I attended deceased from *March 27, 1922* to *March 29, 1922*

that I last saw him alive on *March 29, 1922*

and that death occurred, on the date stated above, at *11 A.* m.

The CAUSE OF DEATH\* was as follows:

*Cardio-Vascular Disease*

CONTRIBUTORY (Secondary) *Pulmonary Congestion* (duration) *3* yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Analysis*

(Signed) *H. S. McLeod* M. D.

*2/30, 1922* Address *2005 D Hill Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Laurel City* *April 2 1922*

20 UNDERTAKER ADDRESS

*George H. Holland* *1631 D Hill Ave*





REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Cerebral Hemorrhage*  
*Phy. had no time*  
*to examine urine*  
*to determine whether*  
*nephritis.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63017

D 63017

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

Robt Garrett Hosp for Children

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

27 N. Carey

ST.

WARD)

2-FULL NAME

Irvin Louis McCain

(a) RESIDENCE NO.

741 Mc Henry

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 5

mos. 11

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 19, 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

City of Baltimore

10 NAME OF FATHER

Larkin McCain

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Sophie Quantmeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Larkin McCain 741 Mc Henry St

15

Filed

Robert P. Harrison,

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 30 1922

17

I HEREBY CERTIFY, That I attended deceased from March 13, 1922, to March 30, 1922, that I last saw him alive on March 29, 1922,

and that death occurred, on the date stated above, at 5:20 A. M.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

double

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death? no Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Physical findings

(Signed)

30, 1922

(Address)

27 N. Carey St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Geo Limbach &amp; Son

642 N. Pratt St

MARGIN RESERVED FOR HANDING  
 N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERYTHING OF INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

MAR 3 1922

Burial Permit Clerk

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63018

## CERTIFICATE OF DEATH.

31 D 63018

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 525 N. Glover St.;

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 525 N. Glover

St.; 10 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Male

## 4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

## 6-DATE OF BIRTH

..... 1 .....  
(Month) (Day) (Year)

## 7-AGE

30 yrs. mos. ds. If LESS than 1 day, ... hrs. or ... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....

Tailor 880

9-BIRTHPLACE,  
(State or Country),

Bohemia

## 10-NAME OF FATHER,

Joseph Stibinsky

11-BIRTHPLACE OF FATHER  
(State or Country),

Bohemia

## 12-MAIDEN NAME OF MOTHER

Mrs. Krom

13-BIRTHPLACE OF MOTHER  
(State or Country),

Bohemia

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

## 15-

Robert P. Harrison,  
Filed....., 191.....

1922 Daniel P. Clark, Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

March 30, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Oct 5 1921 to March 30 1922  
that I saw him alive on March 30 1922

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(Duration)..... yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

Acute Cardiac Disturbance

(Duration)..... yrs. mos. ds.

## (Signed).....

F. F. Rynicki M. D.

3-31-22 (Address) 502 N. Pratt St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer

## DATE OF BURIAL,

April 1, 1922

## 20-UNDERTAKER

Frank Brown

## ADDRESS

1066 N. Pratt St.

D 63019

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63019

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *South Baltimore Hospital* ST. *24* WARD)

2-FULL NAME

*William E. Willett*

(a) RESIDENCE. NO.

*Odenton, Anne Arundel Co., Md.*

(Usual place of abode)  
Length of residence in city or town where death occurred

Yrs.

Mos.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

*Odenton Md.*

WARD.

(If nonresident give city or town and State)

Yrs.

Mos.

Ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Luella Willett*

6 DATE OF BIRTH (month, day, and year)

*May 1886*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*36*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Motorman*

(b) General nature of industry, business, or establishment in which employed (or employer)

*078*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Wash. D.C.*

10 NAME OF FATHER

*Edwin Willett*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Danvers*

12 MAIDEN NAME OF MOTHER

*Edwina Cleaves*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Va.*

14

Informant (Address)

*Luella Willett Odenton Md.*

15

File

*Robert P. Harrison*

Registrar

*1922*

*Marie Harris Clark*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 31 1922*

17 I HEREBY CERTIFY, That I attended deceased from *March 23 1922* to *March 31 1922*

that I last saw him alive on *March 31 1922*

and that death occurred, on the date stated above, at *12:25 A.M.*

The CAUSE OF DEATH\* was as follows:

*acute cholecystitis, acute pancreatitis*

(duration)

*14* ds.

CONTRIBUTORY (Secondary)

*General Peritonitis*

(duration)

*6* ds.

18 Where was disease contracted if not at place of death?

*at home*

Did an operation precede death?

*yes*

Date of

*3/24/22 3/29/22*

Was there an autopsy?

*no*

What test confirmed diagnosis?

*yes*

(Signed)

*Joseph Pokorny M. D. South Baltimore Hospital*

19

(Address)

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Loudon Park*

*Apr. 3 1922*

20 UNDERTAKER

ADDRESS

*Cumboat 501 E. North Ave.*



**CERTIFICATE OF DEATH.**  
[Approved by U. S. Census and American Public Health Asso.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Operation for removal  
of gall bladder. Cause  
of infection unknown.  
Not gonococcus infection*

11-10-21 M&T 1500 Bks.

Spec. - 1-10-21 - M&T - 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63020

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 730 S. Curley ST., WARD)

2-FULL NAME Margaret B. Neale

(a) RESIDENCE NO. 730 S. Curley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 7 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of John E. Neale

6 DATE OF BIRTH (month, day, and year) May 26-1853

7 AGE Years Months Days If LESS than 1 day, hrs or min. 68 7 4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

10 NAME OF FATHER John C. Brandt.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant J. Edgar Neale, Jr. (Address) 730 S. Curley St.

15 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1922

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1922 to March 30, 1922, that I last saw him alive on March 29, 1922, and that death occurred, on the date stated above, at 5:45 a. m. The CAUSE OF DEATH\* was as follows:

Chronic Tubal Replantation

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertensive Heart (duration) 6 yrs. 6 mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. L. Long M. D.

34, 1922 (Address) 2701 Eastern

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Mt. Carmel Cemetery

20 UNDERTAKER Gihlen + Gihlen

DATE OF BURIAL April 1, 1922

ADDRESS 1739 E. Egan

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of QUALITY OF PA-TIENT is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63021

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63021

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 B Rose

ST. 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Augusta Hacker*

(a) RESIDENCE NO. 402 B Rose  
(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

38 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

38 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female white Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Karl Hacker*

6 DATE OF BIRTH (month, day, and year)

*Oct 2 1860*

7 AGE

*62* Years

Months

*26* Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Germany*

10 NAME OF FATHER

*J. Hacker*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Mat. Rose*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Germany*

14

Informant

(Address)

*Karl Hacker  
402 B Rose St*

15

Robert P. Harrison,

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3-28-22*

17 I HEREBY CERTIFY, That I attended deceased from *March 25, 1922* to *March 28, 1922*.

that I last saw her alive on *March 28, 1922*.

and that death occurred, on the date stated above, at *4:15 P. m.*

The CAUSE OF DEATH\* was as follows:

*Labor Pneumonia*

(duration) yrs. mos. ds. *5*  
CONTRIBUTORY *Bronchitis*  
(Secondary) (duration) yrs. mos. ds. *4*

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *George C. Seymour* M. D.

3/29/22 (Address) *1528 E. Monument St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Baltimore Cemetery*

*April 1, 1922*

20 UNDERTAKER

ADDRESS

*Mrs. C. Miller*

*2334 Jefferson St.*

D 63022 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1944 Harlem Ave ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Rice

(a) RESIDENCE. No. 1944 Harlem Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb. 20-22

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Isaac J. Rice

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Mable A. Morris

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia

14

Informant (Address)

Isaac J. Rice 1944 Harlem Ave

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31<sup>st</sup> 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 28, 1922, to March 31, 1922,

that I last saw him alive on March 31, 1922,

and that death occurred, on the date stated above, at 2:00 P. M.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? 1944 Harlem Ave.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Mr. Conrad Bode, M. D.

, 19 (Address) 1900 Maryland Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Penkey Green Co. Md. April 1, 1922

20 UNDERTAKER

ADDRESS

Joseph Syfer 1600 W. North

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 31 1922



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Broncho pneumonia*  
*No infection prior.*

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 63023

HEALTH DEPARTMENT—CITY OF BALTIMORE

63023

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. (als.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-Single, Married, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Robert P. Harrison,

192

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Signed) J. V. T. Harrison, M. D.

(Address) 2802 Edmonson Ave.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER,

ADDRESS

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 31 1922

D 63024 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-001 D 63024

1-PLACE OF DEATH  
City of BALTIMORE: (No. South Balto. General Hospital. 9 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
2-FULL NAME Michael J. Kernan.  
(Residence in Baltimore: No. 1156 E. North Ave. St.; yrs. 69 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.		CORONER'S CERTIFICATE OF DEATH.	
3-SEX, Male.	4-COLOR OR RACE, White.	5-Single, Married, Widowed, or Divorced, (Write the word.) Married	16-DATE OF DEATH, March 29th, 1922. (Month) (Day) (Year)
6-DATE OF BIRTH, September 27th, 1852. (Month) (Day) (Year)		17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above. The CAUSE OF DEATH* was as follows: Cerebral Apoplexy.	
7-AGE, 69 yrs. 6 mos. 2 ds. If LESS than 1 day, hrs. or min.?		(Duration) yrs. mos. ds.	
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Butcher. 013		CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) [Signature] M. D. (Coroner.) Mar. 30, 1922 (Address) 1017 E. Charles St.	
9-BIRTHPLACE, (State or Country), Baltimore, Md.		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
PARENTS.	10-NAME OF FATHER, Ferdinand Kernan.	18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, if not at place of death? Cross St. Market.	
	11-BIRTHPLACE OF FATHER, (State or Country), Ireland.	Former or usual residence.	
	12-MAIDEN NAME OF MOTHER, Elizabeth McKay.	19-PLACE OF BURIAL OR REMOVAL, London Pk.	
	13-BIRTHPLACE OF MOTHER, (State or Country), Ireland.	DATE OF BURIAL, Apr. 1/22	
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Raymond Kernan. (son) (Address) 1156 E. North Ave.		20-UNDERTAKER, Wm. Gerok	
15- Robert P. Harrison, 1922 Registrar. Burial Permit Clerk.		ADDRESS, 502 E North	

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

154383 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63025

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL WARD 18)

2-FULL NAME Mary Francis Diggs

(a) RESIDENCE NO. 870 Patton St. ST. Unknown WARD Unknown

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of  
or WIFE of

Clarence Diggs (son)  
307 Forrest St. City

6 DATE OF BIRTH (month, day, and year) Dec 15, 1862

7 AGE Years 59 Months 3 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

10 NAME OF FATHER Henry Diggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Catherine Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL

(Address)

Robert P. Harris

15 APR 1 - 1922

Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30, 1922

17

I HEREBY CERTIFY, That I attended deceased from March 7, 1922 to March 30, 1922, that I last saw her alive on March 30, 1922, and that death occurred, on the date stated above, at 2:15 P. M.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia, post-operative.

Four days (duration) yrs. mos. 4 ds.

CONTRIBUTORY My renal suffering (Secondary) (duration) 8-9 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 25, 22

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Wm. H. Mott, M. D.

19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Auburn

20 UNDERTAKER

John H. Treadwell

DATE OF BURIAL

Apr 3, 1922

ADDRESS 172

Union St



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Hysteromyomectomy*  
*Noncancerous*  
*Benign Tumor of Uterus*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63026

D 63026

## CERTIFICATE OF DEATH.

101-001

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 W. Cross ST. 21 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susannah Peters(a) RESIDENCE. NO. 505 W. Cross ST. 21 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18637 AGE Years 59 Months — Days — If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)10 NAME OF FATHER Perrey Brown11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)12 MAIDEN NAME OF MOTHER Sarah A. Hassert13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)14 Informant Carrie Jones (Address) 505 W. Cross St.15 PR 1-1922 ROBERT I. HARRISON, Registrar Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 192217 I HEREBY CERTIFY, That I attended deceased from March 1, 1922, to March 29, 1922.that I last saw him live on March 29, 1922, and that death occurred, on the date stated above, at 6:55 P.M.The CAUSE OF DEATH\* was as follows: Pneumonia(duration) yrs. 1 mos. ds.CONTRIBUTORY To Pneumonia (Secondary)(duration) yrs. 1 mos. ds.18 Where was disease contracted if not at place of death? At homeDid an operation precede death? NO Date of —Was there an autopsy? —What test confirmed diagnosis? Charcot's Emphysema(Signed) Chas. H. Jones M. D.19 (Address) 714 S. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Met. Aulim

20 UNDERTAKER

John H. Treadwell

DATE OF BURIAL

Apr 2 1922

ADDRESS

142 W. Hill St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PR 1-1922

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rhs.

D 63027

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63027

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 330 S Pulaski ST., 70 WARD)

2. FULL NAME Theodore Megard

(a) RESIDENCE No. 330 S Pulaski ST., 70 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha E. Megard

6 DATE OF BIRTH (month, day, and year) Mar 3 - 1864

7 AGE Years 58 Months = Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Wash Piano Factory

(c) Name of employer Germany

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER John Megard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Krüger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Bertha E. Megard (Address) 330 S Pulaski St

15 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30 19 22

17 I HEREBY CERTIFY That I attended deceased from 3/27 19 22 to March 30 19 22 that I last saw him alive on March 30 19 22

and that death occurred, on the date stated above, at 10 A. M.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary)

(duration) 3 yrs. 3 mos. 3 ds.

(duration) 1 yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Harry Goldberger M. D.

35 19 22 (Address) 2210 Eutaw Pl

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

London Park Cemetery April 1 19 22  
H. B. Neppert 2236 Fred St

B. - WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. - 1-10-21 - M&T - 1500 Bks.

D 63028

HEALTH DEPARTMENT - CITY OF BALTIMORE

D 63028

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 West Hill Street

ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Thomas Jefferson Joynes

(a) RESIDENCE No. 110 West Hill Street  
(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Negro 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of Sarah Joynes (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5/2/1859

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 63 10 28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Grain

(c) Name of employer Ford

9 BIRTHPLACE (city or town) Accomac Co. Va.  
(State or country)

10 NAME OF FATHER Saboth Joynes

11 BIRTHPLACE OF FATHER (city or town) Accomac Co. Va.  
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Accomac Co. Va.  
(State or country)

14 Informant Mary E. Copper (Daughter)  
(Address) 110 W. Hill St

15 Registrar Robert P. Harrison, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30/1922

17 I HEREBY CERTIFY, That I attended deceased from March 24th 1922 to March 30th 1922

that I last saw him alive on March 30th 1922, 19

and that death occurred, on the date stated above, at 12:20 p.m.

The CAUSE OF DEATH\* was as follows:

Broken Compensation (Cardiac)

(duration) yrs. mos. 8 ds.

CONTRIBUTORY Mitral Ins. Broncho Pneumonia  
(Secondary)  
1 abt 6 mos. 2 (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1610 W. Mulberry St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

APR 1 - 1922



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63029

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 Russel St ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1103 Russel St St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

male

## 4-COLOR OR RACE,

C5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

March 16<sup>th</sup>, 1922  
(Month) (Day) (Year)

## 7-AGE,

yrs. 13 mos. ds.

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

infant  
1009-BIRTHPLACE,  
(State or Country),Balto Md

## 10-NAME OF FATHER,

Herbert Johnson?11-BIRTHPLACE OF FATHER  
(State or Country),

## 12-MAIDEN NAME OF MOTHER

Ellen Johnson13-BIRTHPLACE OF MOTHER  
(State or Country),Md.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herbert Johnson(Address) 1103 Russel St

## 15-

Filed

Robert E. Harrison

191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

March 27, 1922  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

3/27/1922 to 3/27/22 191that I saw him alive on 3/27/22 191and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)Respiratory

(Duration) yrs. mos. ds.

(Signed) Geo. E. Wells M. D.3/29/22 191... (Address) Murray Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Tenements, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

JOHNS HOPKINS HOSPITAL 191...

## 20-UNDERTAKER

## ADDRESS

Commissioner Health MAR 1922

Wm. R. WOODALL

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PR1-1922

C.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63030

## CERTIFICATE OF DEATH.

179 D 63030

### I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 42 E Henrietta ST. 22 WARD)

### 2-FULL NAME

Eliza Libby

(a) RESIDENCE NO.

42 E. Henrietta

ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 5 yrs.

5 mos.

ds.

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Wm N. Libby

6 DATE OF BIRTH (month, day, and year) 10-29-1865

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

36

5

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Dressmaker 869

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Salem N. Y.

(State or country)

10 NAME OF FATHER James Hurley

11 BIRTHPLACE OF FATHER (city or town) N. Y.

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

Mrs Wm Libby  
724 E. 23rd St.

15

Filed

Roberts P. Harrison,

19

Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-29-1922

17

I HEREBY CERTIFY, That I attended deceased from

3-27, 1922, to 3-29, 1922.

that I last saw him alive on 3-29, 1922.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH\* was as follows:

Acute Cardiac Dilatation  
Pulmonary Oedema

(duration) yrs. mos. ds.

CONTRIBUTORY Chronic Nephritis-Multiple Arthritis (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Exam.

(Signed) J. J. Roberts, M. D.

19 (Address) 451 E. 22nd St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park

20 UNDERTAKER

John F. Denny

DATE OF BURIAL

April 1, 1922

ADDRESS

715 Light St.

D 63031

## HEALTH DEPARTMENT—CITY OF BALTIMORE 63031

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *209 N Washington* ST., *6* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

(a) RESIDENCE NO. *209 N Washington* ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *61* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of *Anna Diederichs* or WIFE of6 DATE OF BIRTH (month, day, and year) *Dec 17-1860*7 AGE Years *61* Months *3* Days *14* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Tailor*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto* (State or country)10 NAME OF FATHER *Conrad Hinkel*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Florence Oke*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)14 Informant *Anna Hinkel* (Address) *209 N Washington*15 *PR1-1922* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 30 1922*17 I HEREBY CERTIFY, that I attended deceased from *Mar 21* 19*22* to *Mar 30* 19*22*.that I last saw him alive on *Mar 21*and that death occurred, on the date stated above, at *1:30* a.m.

The CAUSE OF DEATH\* was as follows:

*Arterio Sclerosis*

CONTRIBUTORY (Secondary)

(duration) *2* yrs. mos. ds. *Cerebral Hemorrhage*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Edward J. Leach* M. D.(Address) *1301 Washington*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Baltimore Cemetery*DATE OF BURIAL *Apr 1 1922*20 UNDERTAKER *John Verwig & Co*ADDRESS *2008 Calver*

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63032

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2616 N. Calvert* ST. *12* WARD)2-FULL NAME *Charles B. Henderson*(a) RESIDENCE. NO. *2616 N. Calvert* ST. \_\_\_\_\_ WARD. \_\_\_\_\_

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of *Eva P. Henderson* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *Apr. 17-1872*7 AGE Years *49* Months *11* Days *13* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Merchant*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto. City* (State or country) *Md.*10 NAME OF FATHER *Joseph B. Henderson*11 BIRTHPLACE OF FATHER (city or town) *Balto.* (State or country) *Md.*12 MAIDEN NAME OF MOTHER *Laura Rutherford*13 BIRTHPLACE OF MOTHER (city or town) *N.Y.* (State or country)14 Informant *Eva P. Henderson* (Address) *2616 N. Calvert St.*15 Filed *Robert P. Harrison,* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 30* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *March 15*, 19*20*, to *March 30*, 19*22*.that I last saw him alive on *March 29*, 19*22*.and that death occurred, on the date stated above, at *10:30 A.M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Interstitial Nephritis*(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Urinalysis - blood*(Signed) *John E. McGill* M. D.3/31/1922 Address) *827 N. Charles St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*St. Johns Presbyterian Cem* *Apr. 1* 19*22*

20 UNDERTAKER

*Wm. L. Black* *927 N. Broadway*

PR 1-1922

Burial Permit Clerk

WRITE PLAINLY, WITH EXANDING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.



HEALTH DEPARTMENT—CITY OF BALTIMORE

124 D 63033

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(b) RESIDENCE. NO 2270 Broadway ST., \_\_\_\_\_ WARD.

(Usual place of abode) London, England (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred 8 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 29 1922*

HUSBAND of  
(or) WIFE of *Harry P. Belmont*

6 DATE OF BIRTH (month, day, and year) June 24-1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	72	9	5	

(a) Trade, profession or particular kind of work *St. Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER *John Hathold*

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) *Germany*

12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) *Germany*

14 Informant *Harvey Oldenwurtel*

(Address) 227 E. Broadway

15 1000 19

Burial Permit Clerk.

17 I HEREBY CERTIFY, That I attended deceased from  
*Mar 1<sup>st</sup>* 19 *22* to *Mar 29<sup>th</sup>* 19 *22*

that I last saw her alive on March 29<sup>th</sup>, 1922.

and that death occurred, on the date stated above, at 6:41 P. m.

The CAUSE OF DEATH\* was as follows:

Chromie later  
chromie. bona

CONTRIBUTORY (Secondary) *also Intellectual Alphabet*

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis? *Thyroid* -

(Signed) Robert H. Kennedy, M. D.

3/30/24 (Address) H-129 @ Pacific St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
--	----------------

Holy Redeemer Cem. Apr. 3 192

29 UNDERTAKER ADDRESS

Wm C. Blacke 927 N. Broadway

D 63034

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63034

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

934 S. Kenwood Ave

WARD)

## 2. FULL NAME

Mrs. Anna Spochacz

(a) RESIDENCE NO.

934 S. Kenwood Ave

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

30 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

30 yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Michael Spochacz

6 DATE OF BIRTH (month, day, and year)

1851

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

71

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Poland

10 NAME OF FATHER

George Wojciechowski

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Poland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Poland

14

Informant (Address)

Michael Spochacz 934 S. Kenwood Ave

15

Robert P. Harrison,

19

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 30 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 1917 to March 30 1922

that I last saw her alive on March 30 1922

and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart Disease

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

3/31, 1922 (Address) 2739 Eastern Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAD St Stanislaus

April 3 1922

20 UNDERTAKER

ADDRESS

John Weber 1803 Bank St

B-1-1922

B-1-1922—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63035

## CERTIFICATE OF DEATH.

90 D 63035

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 323-S-Venue ST., 19 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Jordan Gray(a) RESIDENCE NO. 323-S-Venue ST., \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Negro 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed or divorced HUSBAND of (or) WIFE of James H. Gray

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 34 Months 5 Days 8 If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Homemaker 070(b) General nature of industry, business, or establishment in which employed (or employer) General house work(c) Name of employer Lowe's Furniture9 BIRTHPLACE (city or town) Howard Co Md (State or country)10 NAME OF FATHER John Johnson11 BIRTHPLACE OF FATHER (city or town) Howard Co. Md (State or country)12 MAIDEN NAME OF MOTHER Mildred Kelly13 BIRTHPLACE OF MOTHER (city or town) Howard Co Md (State or country)

14

Informant (Address) James H. Gray 323-S-Venue St

15

Filed

Robert P. Harrison

Registrar

PRI-1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-30 19 22

17

I HEREBY CERTIFY, That I attended deceased from 28-march, 19 22 to 30-march, 19 22 that I last saw her alive on March 30, 19 22 and that death occurred, on the date stated above, at 2:25 p.m.

The CAUSE OF DEATH\* was as follows:

Broken Compensation CardiacCONTRIBUTORY (Secondary) Myocardial infarction (duration) yrs. 4 mos. 4 ds.18 Where was disease contracted if not at place of death? at place of deathDid an operation precede death? No Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? Physical Expt(Signed) Walter J. Johnson M.D., 19 22 (Address) 1818 W. Mulberry St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL St. Anthonys CemDATE OF BURIAL April 1, 192220 UNDERTAKER Brown & FrelsandADDRESS 114 W. 1st St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63036

D 63036

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 E Lafayette ST., 179 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Mr. Eliza E. Hagerman(a) RESIDENCE NO. 202 E Lafayette WARD

(Usual place of abode)

(If non-resident give city nr town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Martin L. Hagerman6 DATE OF BIRTH (month, day, and year) Aug 14 = 18487 AGE 73 Years Months Days 7 17 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md10 NAME OF FATHER Christian Berger

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany12 MAIDEN NAME OF MOTHER Marie Reese

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14

Informant

(Address)

Mr. Martin Hagerman  
202 E Lafayette

15

Filed

Robert Y. Harrison,

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 26 1922 to March 31 1922that I last saw him alive on March 31 1922and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH\* was as follows:

Chronic Bright's Disease

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds. 7

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? urinary analysis(Signed) Samuel D. McCann, M. D., 19 (Address) 416 E North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Not Christ Cemetery April 22

20 UNDERTAKER

ADDRESS

F. B. Whippert 2236 Sudbrook

NOTE: B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PRI-1922

Burial Permit closed





REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Probably cholelithiasis*

D 63038

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63038

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *4* WARD)

## 2-FULL NAME

*M. Nathaniel H. Bortner*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE. No.

*Arcadia Md.* ST. *4* WARD. *Arcadia Md.*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *8* yrs. *1* mos. *8* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *?*6 DATE OF BIRTH (month, day, and year) *Apr. 5-1857*7 AGE Years *64* Months *6* Days *25* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Pa.*10 NAME OF FATHER *David N. Bortner*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Pa.*12 MAIDEN NAME OF MOTHER *Mattie Hartman*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Pa.*14 Informant *Mercy Hospital Records* (Address)15 *Robert P. Harrison,*

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 1, 22*17 I HEREBY CERTIFY, That I attended deceased from *Feb 23, 22* to *Apr 1, 22* that I last saw him alive on *Apr 1, 22* and that death occurred, on the date stated above, *10:10 A. M.*

The CAUSE OF DEATH\* was as follows:

*Diabetes Mellitus*CONTRIBUTORY (Secondary) *Diabetes gangrene*

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *John J. Brown*19 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*St. Pauls Church*

20 UNDERTAKER

*Mr. J. Tuckner Davis*

DATE OF BURIAL

*Apr. 1 1922*

ADDRESS

*North & Anna Ave*

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PR1-1922

D 63039

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63039

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1708 E. Madison ST., 7 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mary R. Brown

## (a) RESIDENCE NO.

1708 E. Madison ST.,

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

30 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

Ind. yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

married

## 5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Wife

## 6 DATE OF BIRTH (month, day, and year)

Sept. 15 1885

## 7 AGE

37 Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

House Wife

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Born in Baltimore

## 10 NAME OF FATHER

Unknown

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

## 14

Informant (Address)

John V. Brown 1708 E. Madison

## 15

Filer

Robert P. Harrison,

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-30-1922

## 17

I HEREBY CERTIFY, That I attended deceased from

3-26-1922 to 3-30-1922that I last saw her alive on 3-29-1922and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH\* was as follows:

Mitral Insufficiency(duration) Indefinite yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) W. H. G. G. G. M. D.3-31, 1922 (Address) 611-N-Caroline

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Asbury Cemetery

## DATE OF BURIAL

April 2 1922

## 20 UNDERTAKER

Mrs Robert A. Elliott

## ADDRESS

775- Ashland St

1-10-21—M&T—1500 Bks. (Spec.)

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-10-21—M&T—1500 Bks. (Spec.)

1-10-21—M&amp;T—1500 Bks. (Spec.)

Burial Permit No. 1000



D 63040

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 63040

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Fannon(a) RESIDENCE. No. 442 E. 28th St.ST., 17 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
43	--	--	--	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country) Baltimore,  
Maryland10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Unknown14 Informant Hospital Records,  
(Address) Municipal Hospital.15 Robert P. Harrison,

19

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 19 2217 I HEREBY CERTIFY, That I attended deceased from  
March 14, 19 22, to March 31, 19 22.that I last saw her alive on March 31, 19 22.and that death occurred, on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH\* was as follows:

Erysipelas

CONTRIBUTORY (Secondary)	(duration)	yrs.	mos.	ds.
{ Pneumonia & acute nephritis }	(duration)	yrs.	mos.	ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? Autopsy(Signed) E. Martinez, M. D.3/31/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral April 3 19 22

20 UNDERTAKER

ADDRESS

H. C. Wiedefeld 914 Green

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

PRI-1922

WRITE CAREFULLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD - B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

D 63041

CERTIFICATE OF DEATH

90 D 63041

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No

ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

(Residence in Baltimore: No.

Sr.: 18 yrs. 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3-SEX male 4-COLOR OR RACE Col 5-SINGLE, ~~Married~~ ~~Widowed~~ ~~Or divorced~~ Single

16-DATE OF DEATH Mch 31, 1922 (Month) (Day) (Year)

6-DATE OF BIRTH Oct 1, 1882 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 22, 1922, to Mch 31, 1922

7-AGE 40 yrs. 5 mos. 29 ds. If LESS than 1 day, hrs. or min.?

that I saw him alive on Mch 30, 1922, and that death occurred, on the date stated above, at 3 p.m.

8-OCCUPATION (a) Trade, profession, or particular kind of work Laborer 040 (b) General nature of industry, business, or establishment in which employed (or employer) at foundry on Hamor

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency

9-BIRTHPLACE (State or country) Gambier, Anne Arundel Md

(Duration) I do not know yrs. mos. ds.

10-NAME OF FATHER Benjamin F. Butler

Contributory (SECONDARY) Endocarditis

11-BIRTHPLACE OF FATHER (State or country) Rockingham Virginia

(Duration) I do not know yrs. mos. ds.

12-MAIDEN NAME OF MOTHER Frances Smith

(Signed) F. P. Kellen M. D. (Address) 1214 Madison av

13-BIRTHPLACE OF MOTHER (State or country) Mullsville Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

(Informant) Wm C. Butler

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

(Address) 1328 Myrtle av

Gambier A. C. Co. Md Apr 2, 1922

15.

20-UNDERTAKER ADDRESS

Robert F. Harrison, REGISTRAR

Sam. W. Chase Row 1400 Mosher

Burial Permit Clerk.

PR 1-1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63042

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1029 W. Lammale* ST.: *18* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mary R. Merryman*(Residence in Baltimore: No. *1029 W. Lammale* St.: *70* yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*  
(Write the word.)6-DATE OF BIRTH, *March 2, 1887*  
(Month) (Day) (Year)7-AGE, *71* yrs., *29* mos., *7* ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *Housewife*  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Md*10-NAME OF FATHER, *Thomas S. Taylor*11-BIRTHPLACE OF FATHER, (State or Country), *Md*12-MAIDEN NAME OF MOTHER, *Elizabeth J. Crowl*13-BIRTHPLACE OF MOTHER, (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Chas. E. Merryman*(Address), *1029 W. Lammale St.*

15-

Filed *Robert B. Harrison*, Registrar.

1922 Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Mar 31, 1922*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Mar 15, 1922*, to *Mar 31, 1922*, that I saw her alive on *Mar 30, 1922*, and that death occurred, on the date stated above, at *m.*  
The CAUSE OF DEATH\* was as follows:*Acute Dilatation of Heart*(Duration) *14* yrs., *14* mos., *14* ds.CONTRIBUTORY (Secondary) *Exhaustion*(Signed) *Robert C. Blake* M. D.*Mar 31, 1922* (Address) *1014 W. Lammale St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *71* yrs., *29* mos., *7* ds. In the State *Md.* yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *London Park April 3, 1922*20-UNDERTAKER ADDRESS *Chas. E. Franck 802 Madison Ave*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## Remarks

*Hyperthyroidism No further history.*

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

*lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

<i>Abortion,</i>	<i>Cellulitis,</i>	<i>Childbirth,</i>	<i>Convulsions,</i>
<i>Hæmorrhage,</i>	<i>Gastritis,</i>	<i>Erysipelas,</i>	<i>Meningitis,</i>
<i>Gangrene,</i>	<i>Miscarriage,</i>	<i>Necrosis,</i>	<i>Peritonitis,</i>
<i>Phlebitis,</i>	<i>Pyæmia,</i>	<i>Septicæmia,</i>	<i>Tetanus.</i>

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.



D 63043

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63043

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1737 W. Pratt*)ST.: *14* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Marshall P. Harding*(a) RESIDENCE. No. *1828 Mosheny St*

(Usual place of abode)

ST.: *14* WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *30* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*W*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*July 26 - 1851*

## 7 AGE

*70*

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Soleman*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Alco*

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Proctor's City Md*

## 10 NAME OF FATHER

*James Harding*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Proctor's City Md*

## 12 MAIDEN NAME OF MOTHER

*Sarah G. Fleming*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Proctor's City Md*

## 14

Informant (Address)

*Mr. Maud M. Pink 1737 W. Pratt St*

## 15

Filed

*Robert P. Harrison,*

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*March 25 - 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*March 25, 1922, to March 30, 1922.*that I last saw him alive on *March 30, 1922.*and that death occurred, on the date stated above, at *9:45* m.

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *5*(duration) yrs. mos. ds. *1*

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Herbert K. Coleman, M. D.**March 30 - 1922 3450 Fulton*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*St. Olivet Proctor's City Md**April 3 1922*

## 20 UNDERTAKER

## ADDRESS

*Mr. & Mrs. M. S. Pink**1737 W. Pratt St*

Every item in or information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

PR 1-1922

Burial Permit Clerk.

D 63044

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63044

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Hebrew Hospital

ST.:

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Kathryn Fane

## (a) RESIDENCE. NO.

Dillon, D.C.

ST.

WARD.

Dillon D.C.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

14

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Frank D. Fane

6 DATE OF BIRTH (month, day, and year)

Mar 18 1895

7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pa

10 NAME OF FATHER

Marcus Copeland

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Rosa Sulion

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant (Address)

Marcus Copeland 18 E. Lombard St

15

Filed

19

ROBERT P. BARTON

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 30 1922

17

I HEREBY CERTIFY, That I attended deceased from

Mar 16, 1922, to Mar 30, 1922, that I last saw her alive on Mar 30, 1922,

and that death occurred, on the date stated above, at 5:48 pm.

The CAUSE OF DEATH\* was as follows:

Acute cardiac dilatation

(duration) 8 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

1/30, 1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Hebrew

April 2 1922

20 UNDERTAKER

ADDRESS

J. Ahrens &amp; Co

1611 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 1-1922

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

153602

HEALTH DEPARTMENT—CITY OF BALTIMORE

63045

63045

CERTIFICATE OF DEATH.

X 84

D 63045

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

WARD)

2. FULL NAME

Hilton A. Lomax

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

Spencer, H. C.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Yrs.

Mos.

How long in U. S., if of foreign birth?

Yrs.

Mos.

Da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

Mrs. Minnie Lomax

6 DATE OF BIRTH (month, day, and year)

Dec. 11, 1871

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

50

3

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Prop. Moving Picture Show

(b) General nature of industry, business, or establishment in which employed (or employer)

086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

H. C.

10 NAME OF FATHER

William Lomax

11 BIRTHPLACE OF FATHER (city or town) (State or country)

H. C.

12 MAIDEN NAME OF MOTHER

Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

H. C.

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

APR 2 - 1922

ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 31, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 3, 1922, to March 31, 1922

that I last saw him alive on March 31, 1922

and that death occurred, on the date stated above, at 7:50 P. M.

The CAUSE OF DEATH\* was as follows:

Brain Tumor

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary)

Meningitis

(duration) yrs. mos. 49 da.

18 Where was disease contracted

if not at place of death? Spencer, N. C.

Did an operation precede death? Yes Date of Feb 10, 1922

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed)

P B Mac Cready, M. D.

, 19

(Address)

Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVING

DATE OF BURIAL

Spencer N. C.

4/2/22

20 UNDERTAKER

Wm. H. Schaeffer - 1814 E. Monument St.

HEALTH DEPARTMENT—CITY OF BALTIMORE **MD 63046****D 63046**

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. **JOHNS HOPKINS HOSPITAL** 7

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

**Henry Gilmer**

## (a) RESIDENCE NO.

**Lewisburg, W. Va. ST.**

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

**Male**

## 4 COLOR OR RACE

**White**

## 5 Single, Married, Widowed, or Divorced, (write the word)

**Married**

## 5a If married, widowed, or divorced

**HUSBAND of****Betty Gilmer**

## 6 DATE OF BIRTH (month, day, and year)

**1858**

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

**64**

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

**Lawyer**

(b) General nature of industry, business, or establishment in which employed (or employer)

**OK**

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

**W. Va.**

## 10 NAME OF FATHER

**Henry Gilmer**

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

**W. Va.**

## 12 MAIDEN NAME OF MOTHER

**Sallie Collison**

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

**W. Va.**

## 14

Informant (Address)

**JOHNS HOPKINS HOSPITAL**  
**Records**

## 15

**APR 2 - 1922****ROBERT R. KRAUTER,****Bureau Permit Clerk**

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) **April, 1922**

## 17

I HEREBY CERTIFY, That I attended deceased from **April, 1922** to **April, 1922** that I last saw him alive on **April 1, 1922** and that death occurred, on the date stated above, at **10<sup>00</sup> P. M.**

The CAUSE OF DEATH\* was as follows:

**Diabetes mellitus**(duration) **7** yrs. mos. ds.CONTRIBUTORY (Secondary) **Diabetic coma**

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? **Yes**. Date of **April, 22**Was there an autopsy? **Yes**What test confirmed diagnosis? **Blood chemistry**(Signed) **W. H. H. M. D.**41, 1922 (Address) **Johns Hopkins Hosp.**

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

**Resurrection West da April 2, 1922**

## 20 UNDERTAKER

**Joseph Ahrens**

## DATE OF BURIAL

## ADDRESS

**221 N. Bay**

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63047

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 737 Broadway ST., 17 WARD)

## 2-FULL NAME

William H. Jones

## (a) RESIDENCE No.

737 Broadway ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 24 - 18887 AGE 34 Years Months 5 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant (Address)

## 15

APR 2 - 1922

ROBERT H. KRAUTER

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 24, 1922

17

I HEREBY CERTIFY, That I attended deceased from Mar. 24, 1922 to Mar. 24, 1922, that I last saw him alive on Mar. 28, 1922and that death occurred, on the date stated above, at 3:25 p.m.

The CAUSE OF DEATH\* was as follows:

Hemorrhage of nose & from gum  
and teeth

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Chemical(Signed) Ac. Dr. Oliver, M. D., 19 (Address) 927 Madison

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVING  
Indeburn City Apr 2 1922

20 UNDERTAKER

ADDRESS

George H. Herliand 1631 Union  
St. Baltimore

D 63048

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 63048

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *602 N. Belair Road* ST. *Roseburg* WARD *2*)

## 2. FULL NAME

*Princess Koenig*

## (a) RESIDENCE NO.

*602 N. Belair Road* ST. *Roseburg* WARD *2*

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *John E. Koenig*6 DATE OF BIRTH (month, day, and year) *Feb 23 1857*7 AGE Years *65* Months *1* Days *8* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Homemaker 037*(b) General nature of industry, business, or establishment in which employed (or employer) *at home*

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Maryland*10 NAME OF FATHER *Christian Fischer*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Mary E. Koenig*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)14 Informant *John E. Koenig* (Address) *602 N. Belair Road*15 *APR 2 - 1922* *ROBERT R. KRAUTER* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 1 1922*17 I HEREBY CERTIFY, That I attended deceased from *Mch. 31*, 1922, to *April 1*, 1922, that I last saw him alive on *Apr. 1*, 1922, and that death occurred, on the date stated above, at *9:10 P. m.* The CAUSE OF DEATH\* was as follows:*Cerebral Hemorrhage*CONTRIBUTORY *Ch. Replectic, Ch. Endocarditis* (duration) yrs. mos. 2 ds. *and Arteriosclerosis* ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *A. J. Williams* M. D. *4/2, 1922* (Address) *13 Bel Air Rd., Roseburg*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

*Holy Redeemer Cemetery* *April 22*

20 UNDERTAKER

ADDRESS

*Frank L. Lashmone* *Fullerton*

N. B.—WRITE PLAINLY, WITH CAREFULNESS. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 63049  
PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1606 St Appellton ST. 15 WARD)

2-FULL NAME Harry G Blum

(a) RESIDENCE NO. 1606 St Appellton ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Jennie Blum

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

30 — —

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Clothing Cutter

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Blum

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Jack Lewis 1439 E Baltimore St

15

Filed

APR 2 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-31-1922

17

I HEREBY CERTIFY, That I attended deceased from 3-24-1922, to 3-31-1922, that I last saw him live on 3-31-1922, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia (lobar)

CONTRIBUTORY (Secondary) Gruppe (duration) yrs. mos. 5 ds.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 20 Date of

Was there an autopsy? 20

What test confirmed diagnosis?

Ordinary tests

(Signed)

St. J. H. M. D.

4-1-1922 Address 2202 W. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Heavenly Rest

DATE OF BURIAL

April 2 1922

20 UNDERTAKER

Jack Lewis 1439 E Baltimore St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 63050

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. ....)

ST. 18

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. ....)

St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

married

6-DATE OF BIRTH,

Month Day Year

7-AGE,

36 yrs. mos. da.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

APR 2 - 1922

ROBERT H. KNAUTER,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Patrolman Dis. Heart. Acute Cardiac Dilatation

CONTRIBUTORY (Secondary)

(Signed) M. D. (Coroner.)

(Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....da. In the State....yrs....mos....da.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Wheeler Road

4-2, 1922

20-UNDERTAKER

ADDRESS

Jack Lewis 1439 E. Baltimore

1439 E. Baltimore



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 63051

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *918 Linden Ave.* ST.; *19* WARD)

## 2-FULL NAME

*Philip Thomas Reilly*(Residence in Baltimore: No. *918 Linden Ave.*

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *61* yrs., *2* mos., *11* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

## 6-DATE OF BIRTH,

*January 21, 1861*  
(Month) (Day) (Year)

## 7-AGE,

*61* yrs., *2* mos., *11* ds.

If LESS than 1 day, ...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*retired*

## 9-BIRTHPLACE, (State or Country),

*Baltimore City*

## 10-NAME OF FATHER,

*Philip Reilly*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Ireland*

## 12-MAIDEN NAME OF MOTHER

*Elizabeth Fitzpatrick*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Ireland*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Peter F. Reilly*(Address) *332 Federal St.*

## 15-

APR 2 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*April 1, 1922*  
(Month) (Day) (Year)

## 17-I HEREBY CERTIFY, That I attended deceased from

*March 31 1922* to *April 1 1922*that I saw him alive on *April 1 1922*and that death occurred, on the date stated above, at *12<sup>10</sup> P. m.*

The CAUSE OF DEATH\* was as follows:

*broncho-pneumonia*

(Duration) ... yrs. ... mos. ... ds.

## CONTRIBUTORY (Secondary)

*bronchitis (chronic) with asthma more or less*(Signed) *Charles O. Moran* M. D.*102*, 101... (Address) *5 E. Read St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*New Cathedral Cemetery*

## DATE OF BURIAL,

## 20-UNDERTAKER

*W. W. Shivers*

## ADDRESS

*1018 Edmondson Ave.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63052

## CERTIFICATE OF DEATH.

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 180 Falls Road ST.; 13 WARD)

## 2-FULL NAME

(a) RESIDENCE. No. 180 Falls Road ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Mary Franklin

6 DATE OF BIRTH (month, day, and year) Unknown 1876

7 AGE 46 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Timon, Iowa

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mary Franklin 180 Falls Road

15 Filed APR 2 - 1922

HUBERT K. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/20 1922

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1922, to March 31, 1922, that I last saw him alive on March 30, 1922.

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

## CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George L. Drane M. D.

Address 721 N. Eutan

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Timon, Iowa APR 2 1922

20 UNDERTAKER ADDRESS 578

Samuel Hensley M.D.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D

63053

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63053

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 581 Dolphin

2-FULL NAME

(Residence in Baltimore: No. 581 Dolphin

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 70 yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE

MARRIED

6-DATE OF BIRTH,

Unknown, 1852  
(Month) (Day) (Year)

7-AGE,

Mo. yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,  
(State or Country),

Balt Md

10-NAME OF FATHER,

Samuel B Banks

11-BIRTHPLACE OF FATHER  
(State or Country),

Balt Md

12-MAIDEN NAME OF MOTHER

Sarah Baseman

13-BIRTHPLACE OF MOTHER  
(State or Country),

Balt Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Samuel W. Banks

(Address)

581 Dolphin St

15-

APR 2 - 1922

Filed

191

ROBERT R. KRAUTER,

Sanitary Police Officer

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 1, 1922  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest thereon and from the evidence obtained by said inquest, au-

gny had that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Organic heart disease (myocardial degeneration)

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.

April 1, 1922 (Address) 2802 E. ...

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

4/3/22

20-UNDERTAKER

William Cook

ADDRESS

502 1/2 North Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63054

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 N. Belwood ST., 7 WARD)

2-FULL NAME Henry Bufford

(a) RESIDENCE NO. 600 N. Belwood ST.,

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Eliza Beth Bufford

6 DATE OF BIRTH (month, day, and year) Jan 29 1853

7 AGE Years 69 Months 2 Days 2 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Stebbsville

10 NAME OF FATHER

John Bufford

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Dorothy Ann

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14 Informant Mrs Elizabeth Bufford

(Address)

600 N. Belwood

15 ROBERT R. KRAUTER, Registrar

APR 2 - 1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31 1922

17 HEREBY CERTIFY, That I attended deceased from Sept. 21, 1921, to March 31, 1922.

that I last saw him alive on March 22, 1922, and that death occurred, on the date stated above, at 8 30 a. m.

The CAUSE OF DEATH\* was as follows:

Melanotic Sarcoma of back with metastases to both axillae and lungs.

(duration) 1 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of Oct 3, 1921

Was there an autopsy? no

What test confirmed diagnosis? Macroscopic examination

(Signed) Mark D. Lyman, M. D.

, 19 (Address) 41 W. Pratt St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Stebbsville

20 UNDERTAKER

H. M. Corle

DATE OF BURIAL

April 3 1922

ADDRESS

A. G. M.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



1. E. - WRITE PLAINLY, WITH CAPITAL LETTERS. PHYSICIANS should state date and place of death. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63055 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63055

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *South Balto. Gen. Hospital. ST. 23* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

*Grace Sothoron*

(a) RESIDENCE. NO.

*1533 S. Manover St.*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 MARRIAGE *Single* (Married, Widowed, or Divorced, give the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Jan 4 - 1920*

7 AGE Years *✓* Months *✓* Days *✓* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Stone*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore Maryland*

10 NAME OF FATHER *Andrew J. Sothoron*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Maryland*

12 MAIDEN NAME OF MOTHER *Grace B. Husley*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Maryland*

14 Informant (Address) *Andrew J. Sothoron 1533 S. Manover St.*

15 Filed *1922* ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 1 1922*

17 I HEREBY CERTIFY, That I attended deceased from *March 30* 1922 to *April 1* 1922, that I last saw her alive on *April 1* 1922, and that death occurred, on the date stated above, at *2:30 A* m. The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*

(duration) yrs. mos. ds. *20*

CONTRIBUTORY (Secondary)

*Empyema (left base)*

(duration) yrs. mos. ds. *6*

18 Where was disease contracted if not at place of death? *at home*

Did an operation precede death? *yes* Date of *3/30/22*

Was there an autopsy? *no*

What test confirmed diagnosis? *none*

(Signed) *Joseph Bokorny* M. D. 19 (Address) *South Balto. Gen. Hospital.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Cedar Hill Cemetery 4/3 1922*

20 UNDERTAKER

*William Cook* ADDRESS *5029 North*

## HEALTH DEPARTMENT - CITY OF BALTIMORE

D 63056

D 63056

## CERTIFICATE OF DEATH.

101-001

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3228 Toomey ST., No. 10 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Erma E. Schepleny

(a) RESIDENCE NO. 3228 Toomey ST., WARD

(Usual place of abode)

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth 10 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of William J. Schepleny

6 DATE OF BIRTH (month, day, and year) April 8, 1895

7 AGE 26 Years Months Days If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

## 14

Informant (Address) William J. Schepleny 3228 Toomey St.

## 15

APR 2 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1922

I HEREBY CERTIFY, That I attended deceased from March 29, 1922, to April 1, 1922, that I last saw her alive on March 31, 1922, and that death occurred, on the date stated above, at 3 30 m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary) Acute Myocarditis (duration) yrs. mos. ds. 75 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) A. B. Titlow M. D.

4/1, 1922 (Address) 315 S. Highland

\*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt. Carmel Cem. 4/4/1922

UNDERTAKER

ADDRESS

William Cook 302 E. North

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 63057

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

ST.

WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

File APR 2 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
March 6 22, to April 1 22,  
that I last saw him alive on April 1, 1922,  
and that death occurred, on the date stated above, at 10:52 a.m.

The CAUSE OF DEATH\* was as follows:

Sub-acute Endocarditis

CONTRIBUTORY

(Secondary)

18 Where was disease contracted  
If not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

19

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 63058

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 63058

Registered No. C.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *St. Joseph Hospital* St. *6* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *2212* St.; yrs. *15* mos. *6* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Single*

6-DATE OF BIRTH *Not Known* 1. (Month) (Day) (Year)

7-AGE *25* yrs. *15* mos. *6* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work *Tailor*  
(b) General nature of industry, business, or establishment in which employed (or employer) *080*

9-BIRTHPLACE, (State or Country). *Balto*

10-NAME OF FATHER *Frank Soukup*

11-BIRTHPLACE OF FATHER, (State or Country). *Bohemia*

12-MAIDEN NAME OF MOTHER *Anna Casarek*

13-BIRTHPLACE OF MOTHER, (State or Country). *Bohemia*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank Soukup*(Address) *2212 Ashland W*

15-APR 2 - 1922

Filed

192

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Apr 5 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said... (Inquest, autopsy or inquiry.)  
and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Gun shot wound*  
(Duration) *38* yrs. *15* mos. *6* ds.

CONTRIBUTORY (Secondary) *Gun shot wound*

(Signed) *J. C. Williams* M. D.  
(Coroner.)

192 (Address) *1906 Ashland W*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).  
At place of death... yrs. *15* mos. *6* ds. State... yrs. *15* mos. *6* ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*Holy Redeemer* *Apr 3 1922*

20-UNDERTAKER, ADDRESS

*Frank Crackdon* *1906 Ashland W*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63059

## CERTIFICATE OF DEATH.

90 D 63059

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2009 E Fairmont Ave ST., 6 WARD)2-FULL NAME Edna E Connelly(a) RESIDENCE NO. 2009 E Fairmont Ave ST., 6 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a ~~Married, widowed, or divorced~~  
HUSBAND of  
(or) WIFE of Lourence Connelly6 DATE OF BIRTH (month, day, and year) Sept. 18827 AGE Years Months Days If LESS than 1 day, hrs. or min. 40

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md10 NAME OF FATHER Robt Reed11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md12 MAIDEN NAME OF MOTHER Edna Norris13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md14 Informant Lourence Connelly  
(Address) 2009 E Fairmont Ave15 APR 2 - 1922 ROBERT H. KRAUTER  
Registrar

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31st 192217 I HEREBY CERTIFY, That I attended deceased from Mar 27, 1922, to Mar 31, 1922, that I last saw him alive on Mar 30, 1922, and that death occurred, on the date stated above, at 7 a m.  
The CAUSE OF DEATH\* was as follows:  
mitral regurgitation

CONTRIBUTORY (Secondary)

(duration) yrs. ? mos. 5 ds.

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of noneWas there an autopsy? noWhat test confirmed diagnosis? none(Signed) J. P. Lee M. D.41, 1922 (Address) 1206 E. Lexington

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Baltimore Cemetery April 3 1922  
20 UNDERTAKER Robt Turner Inc 1442  
W Broadway

N.B.—WRITE IN PLAIN INK. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63060

## CERTIFICATE OF DEATH.

47 D 63060  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 J. Fulton Ave. ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rena B. Hilton

(Residence in Baltimore: No. 107 J. Fulton Ave. St. 41 yrs., 8 mos. 5 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-STATUS, MARRIED, Married (Write the word.)

6-DATE OF BIRTH, July 26, 1880 (Month) (Day) (Year)

7-AGE, 41 yrs., 8 mos., 5 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Housewife (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

10-NAME OF FATHER, Elias Frank Lambert

11-BIRTHPLACE OF FATHER (State or Country), Maryland Worcester Co

12-MAIDEN NAME OF MOTHER Emma Virginia Neal

13-BIRTHPLACE OF MOTHER (State or Country), Maryland Worcester Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George B. Hilton

(Address) 107 J. Fulton Ave.

15-

APR 2 - 1922 Filed 191. ROBERT R. KRAUTER, Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mch 31, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mch 14 1921, to Mch 31 1921, that I saw her alive on Mch 31 1921, and that death occurred, on the date stated above, at 145 P. The CAUSE OF DEATH\* was as follows:

Cancer of Right Breast (Duration) 4 yrs., mos., ds.

CONTRIBUTORY (Secondary)

(Signed) Chas. A. Schaefer M. D. Mch 31, 1922 (Address) 57 J. Fulton Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem DATE OF BURIAL, Apr. 3, 1922

20-UNDERTAKER, Rept. B. Cook ADDRESS, 1063 N. E. St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 63061

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 N. Gilmor

ST., 16 WARD)

## 2-FULL NAME

Annie Parks

## (a) RESIDENCE NO.

1207 N. Gilmor

(Usual place of abode)

ST.,

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

James H. Parks

6 DATE OF BIRTH (month, day, and year) June 3<sup>rd</sup> 1847

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

74

9

29

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER Bernard Morris

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER Annie

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant Miss Annie L. Parks  
(Address) 1207 N. Gilmor St.

15

APR 2 - 1922 ROBERT R. KRAUTER,  
Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1st 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 22, 1922, to Apr 1, 1922, that I last saw her alive on March 31<sup>st</sup>, 1922, and that death occurred, on the date stated above, at 4.30 A. M.  
The CAUSE OF DEATH\* was as follows:

Chronic myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

M. D.

42, 1922 (Address) 720 N. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral Cem Apr. 4, 1922

20 UNDERTAKER

ADDRESS

Joseph B Cook 1003 N. Baltimore St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 63062

1-PLACE OF DEATH

CITY OF BALTIMORE: No 516 W SARATOGA

ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JOSEPHINE KAZLAVCKUTE

(a) RESIDENCE. No 516 W SARATOGA

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX FEMALE 4 COLOR OR RACE WHITE 5 Single, Married, Widowed, or Divorced (write the word) SINGLE

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE 49 Years • Months • Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work TAILOR

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer NOT KONW

9 BIRTHPLACE (city or town) (State or country)

LITHVANIA

10 NAME OF FATHER CAZEMER KAZLAVCKAS

11 BIRTHPLACE OF FATHER (city or town)

(State or country) LITHVANIA

12 MAIDEN NAME OF MOTHER MARY MACUTE

13 BIRTHPLACE OF MOTHER (city or town) (State or country) LITHVANIA

14

Informant MRS LEIKUS (Address) 516 W SARATOGA

15

APR 2 - 1922 ROBERT A. KNASTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1922

17

I HEREBY CERTIFY, That I attended deceased from March 24, 1922, to March 24, 1922,

that I last saw her alive on March 24, 1922,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings.

(Signed) John A. Buchness, M. D.

, 19 (Address) 650 Washington Blvd.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Italy Redeemer

7/3 1922

20 Undertaker

Jm Gubman 4250 N. Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 63063

## CERTIFICATE OF DEATH.

REGISTERED NO. 10 D 63063

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1328 HOLLINS

ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME ALINORA D JENKINS

(a) RESIDENCE No. 1328 HOLLINS

ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX FEMALE 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 7th 1915

7 AGE 5 Years 3 Months 28 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No

(b) General nature of industry, business, or establishment in which employed (or employer) No

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

10 NAME OF FATHER Antanas Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Magdalena Bulota

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Antanas Jenkins (Address) 1328 Hollins Street

15 APR 2 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1922

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1922, to April 1, 1922.

that I last saw her alive on April 1, 1922.

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH\* was as follows:

Diphtheria

(duration) yrs. mos. 10 ds.  
CONTRIBUTORY Acute Nephritis  
(Secondary) (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Culture of Throat (Signed) J M Delaney, M. D.

621 Columbia St. Address

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Stanislovas

4/2 th 1922

20 UNDERTAKER

ADDRESS

John Grebliauckas

425 Spaca

st

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 63064  
1-PLACE OF DEATHCITY OF BALTIMORE: (No. *St. Josephs Hospital 9* ST. WARD)2-FULL NAME *Loretta Koch*(Residence in Baltimore: No. *1130 Montpelier* St., *life* yrs., *life* mos., *life* ds.)REGISTERED NO. C *63064*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *8 April 14, 1*

(Month) (Day) (Year)

7-AGE *29*

yrs. mos. ds.

If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Insurance*(b) General nature of industry, business, or establishment in which employed (or employer) *037*9-BIRTHPLACE, (State or Country) *Balti Md.*10-NAME OF FATHER, *Joseph Jacobs*11-BIRTHPLACE OF FATHER (State or Country), *Md.*12-MAIDEN NAME OF MOTHER *Catharine Boyce*13-BIRTHPLACE OF MOTHER (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Henry H. Koch*(Address) *1130 Montpelier St.*

15-

APR 2 - 1922

ROBERT R. KRAUTER,

Filed .....

191

Burial Permit Clerk Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *3/30/1922*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *3/28/1922*, to *3/30/1922*,that I saw h *on* alive on *3/30/19122*,and that death occurred, on the date stated above, at *78* m.

The CAUSE OF DEATH\* was as follows:

*Supercardiac Insufficiency*

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) *Emphysema, Myocarditis*

(Duration) .... yrs. .... mos. .... ds.

(Signed) *Frank E. Murrin, D.*....., 191... (Address) *St. Josephs Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, *Balti Cem.*DATE OF BURIAL, *4/3/1922*20-UNDERTAKER *Geo J. Ruth*ADDRESS *1735 Harbor Ave.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63065

CERTIFICATE OF DEATH.

D 63065  
100-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 121 N. Amity ST., 18 WARD)

2-FULL NAME

Minerva Taylor

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

121 N. Amity ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life mos.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced. (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1/20/21

7 AGE

Years

Months

Days

LESS than 1 day, hrs. or min.

1

2

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

Nil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md

10 NAME OF FATHER

Henry Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Hyattsville Md

12 MAIDEN NAME OF MOTHER

Lizzie Whitehead

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Hyattsville Md

14

Informant (Address)

Henry Taylor 121 N. Amity St.

15

APR 2 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/31/22

17

I HEREBY CERTIFY, That I attended deceased from

3/24/22 to

3/31/22

that I last saw alive on

3/31/22

and that death occurred, on the date stated above, at

3:45 p.m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

W. S. Howell M. D.

(Address)

119 W. Carrollton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Gibbons Cem

April 1922

20 UNDER-TAKER

ADDRESS

Brown & Tiesland

D 63066 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 63066

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO *President Hospital* ST.: *5* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Rachel Bell*

## (a) RESIDENCE. NO.

*421 S. Spring*

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *22* yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Female*

## 4 COLOR OR RACE

*Colored*

## 5 Single, Married, Widowed, or Divorced (write the word)

*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

*1900*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*22* — —

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Domestic*

(b) General nature of industry, business, or establishment in which employed (or employer)

*general*

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*

## 10 NAME OF FATHER

*James Bell*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Md.*

## 12 MAIDEN NAME OF MOTHER

*May Smith*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Md.*

## 14

Informant

(Address)

*Mary Bell 421 S. Spring St.*

## 15

F

*APR 8 - 1922*

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*March 31, 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*March 18, 1922, to March 31, 1922*that I last saw him alive on *March 31, 1922*and that death occurred, on the date stated above, at *3:15 P.M.*

The CAUSE OF DEATH\* was as follows:

*Acute interstitial nephritis*

(duration) yrs. mos. ds.

CONTRIBUTORY *Metal requisition*

(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted? *421 S. Spring St.*

If not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical*(Signed) *Dr. C. H. Harrison* M. D.Address *1520 E. Monument St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*St. Andrew**April 3 1922*

## 20 UNDERTAKER

ADDRESS *1140**Brown & Ireland*

mation should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63067

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 821 Airquith, ST. 10 WARD)

## 2. FULL NAME

William Heimiller

## (a) RESIDENCE NO.

821 Airquith

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Widower

## 5a If married, widowed, or divorced

HUSBAND of

Wilhelmina Heimiller

## 6 DATE OF BIRTH (month, day, and year)

Dec 30<sup>th</sup> 1836

## 7 AGE

Years 85

Months 3

Days —

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Germany

## 10 NAME OF FATHER

John Heimiller

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Catherine Jaeger

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

## 14

Informant (Address)

Lena Heimiller 821 Airquith st

## 15

Filed

APR 2 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30 1922

17

I HEREBY CERTIFY, That I attended deceased from March 19, 1922, to March 30, 1922, that I last saw him alive on March 30, 1922,

and that death occurred, on the date stated above, at 10.50 P. m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 20

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

Address 1541 E. Bay St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

Baltimore Cemetery

Apr 3<sup>rd</sup> 1922

20 UNDERTAKER

ADDRESS

George Schilling &amp; Sons 1126 E. Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63068

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

57 D 63068  
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 43 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

54 yrs.

— mos.

— ds.

How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Married Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of

Charles Eugene Kelly

6 DATE OF BIRTH (month, day, and year)

Aug. 1-1850

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

71

7

29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Harford Co. Maryland

10 NAME OF FATHER

John C. Proctor

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Harford Co. Maryland

12 MAIDEN NAME OF MOTHER

Rebecca C. —

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Mr. Vernon F. Kelly 3705 Falls Road

15

APR 2 - 1922

ROBERT K. KRAUTER, Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30 1922

I HEREBY CERTIFY, That I attended deceased from 3/17/22, 19, to 3/30/22, 19, that I last saw her alive on 3/30/22, 19, and that death occurred, on the date stated above, at 855 P. M.

The CAUSE OF DEATH\* was as follows:

Diabetes mellitus

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary)

humerus fracture

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. W. Scott M. D.

, 19 (Address) St Agnes Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

NOVAH Mount Ridge

April 3 1922

20 UNDERTAKER

ADDRESS

Horace H. Burgee

363 Falls Road

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63069

## CERTIFICATE OF DEATH.

REGISTERED NO. C

63069

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1019 Myrtle Ave* ST. *17* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *1019 Myrtle Ave* St.: *5* yrs., *2* mos. *6* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE. *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*  
(Write the word.)

6-DATE OF BIRTH. *Jan.* *1891*  
(Month) (Day) (Year)

7-AGE. *31* yrs. *—* mos. *—* ds. 10 LESS than 1 day, *—* hrs. or *—* min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *Domestic*  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Va*

10-NAME OF FATHER, *Unknown*

11-BIRTHPLACE OF FATHER (State or Country), *Unknown*

12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Abraham L. Cronwell*(Address) *1416 McCleary St.*

15-

Filed

APR 2 - 1922

ROBERT R. KRAUTER

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *March 30*, 19*22*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *March 20*, 19*22*, to *March 30*, 19*22*, that I saw her alive on *March 30*, 19*22*, and that death occurred, on the date stated above, at *6:45* m.

The CAUSE OF DEATH\* was as follows:

*Acute Indigestion*  
(Duration) *2 hours*

CONTRIBUTORY (Secondary) *No History*

(Signed) *J. C. Cooper* M. D.  
*3-31-22* (Address) *163 Myrtle Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs. *—* mos. *—* ds. In the State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Mt. Auburn Cemetery* DATE OF BURIAL, *April 2, 1922*

20-UNDERTAKER, *Jno. M. Hansen* ADDRESS *1244 Ething St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Physician should be supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. - 1-10-21-M&T-1500 Bts.

154874  
D 63070

HEALTH DEPARTMENT—CITY OF BALTIMORE, D 63070

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 146 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mannie Frisky.

(a) RESIDENCE NO. 1325 1/2 Mount St. ST. City WARD  
(Usual place of abode) Unknown (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. 40 How long in U. S., if of foreign birth? yrs. 40 mos. 40

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married.

5a If married, widowed, or divorced HUSBAND of Joseph A. Frisky (husband) (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 9, 1894

7 AGE Years 27 Months 6 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work 037  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Charles Burns.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy Waters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant. JOHNS HOPKINS HOSPITAL (Address) Secod

15 File APR 2 - 1922 ROBERT K. KRAUTER Burial Permit 142

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1922

17 HEREBY CERTIFY, That I attended deceased from March 29, 1922 to March 31, 1922, that I last saw her alive on March 31, 1922 and that death occurred, on the date stated above, at 125 a.m.

The CAUSE OF DEATH\* was as follows:  
Puerperal Septicemia  
Genital perforation

(duration) yrs. 5 mos. 5 ds.  
CONTRIBUTORY Miscarriage (Involution)  
(Secondary) (duration) yrs. 7 mos. 7 ds.

18 Where was disease contracted if not at place of death? since marriage

Did an operation precede death? yes Date of March 29, 22

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) Leo Brady M. D.  
, 19 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL St. Auburn DATE OF BURIAL Apr 3, 1922

20 UNDERTAKER John H. Treadwell ADDRESS 142 W. Hill St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63071

## CERTIFICATE OF DEATH.

D 63071

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 11 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

ST.

WARD.

Length of residence in city or town where death occurred

yrs.

6 mos.

4

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept. 28, 1911

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

File

APR 2 - 1922

ROBERT B. KRISTOFF

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 5<sup>th</sup> 1922, to April 2, 1922, that I last saw him alive on April 1<sup>st</sup>, 1922,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH\* was as follows:

Epidemic Cerebro-Spinal Meningitis

CONTRIBUTORY (Secondary) above at Venetian (duration) yrs. 2 mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. Michael S. Brown M. D.

19 (Address) 206 E. Indaw Place

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Friendship

4-2 1922

20 UNDERTAKER

ADDRESS

Jack Lewis

1429 E. Balto

tion should be carefully supplied. AGE, should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Physicians should state  
Exact statement of OCCUPA-  
TION is very important. See instructions on back of certificates.

Spec.-1-10-21-M&T-1500 Bks.

D 63072

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 St. Eden St. 10 WARD)

2-FULL NAME

Meyer Hendleman

(a) RESIDENCE NO.

1210 St. Eden St.

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,  
or Divorced, (write the word)

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Bailey Hendleman

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

50

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Cabinet

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Maker

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Russell

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Russell

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Russell

14

Informant  
(Address)

Jack Lewis  
1439 E. Bath

15

APR 2 - 1922 ROBERT R. KRAUTER,

Registrar  
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 2 1922

17

I HEREBY CERTIFY, That I attended deceased from  
April 1 - 1922 to April 2 - 1922  
that I last saw him alive on April 2 1922  
and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam.

(Signed) Herman Seidel M. D.

19 (Address) 2404 E. Bath

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Shaw Mt. Carmel

20 UNDERTAKER

Jack Lewis, 1439 E. Bath

DATE OF BURIAL

4-2-22

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE **D 63073****D 63073**

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital*)ST.: *14* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Baby Clara Perlman.*(a) RESIDENCE. No. *1513 N. Linden Ave*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White.*

5 Single, Married, Widowed, or Divorced (write the word)

*Single.*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*1917*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*5*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Bactr. Md*

10 NAME OF FATHER

*Louis Perlman*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Russia*

12 MAIDEN NAME OF MOTHER

*Beckie Rudman*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Russia*

14

Informant

(Address)

*Louis Perlman**1513 Linden Ave*

15

File

**APR 2 - 1922****ROBERT R. KRAUTER**

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Apr 2 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*March 25*, 19*22*, to *April 2*, 19*22*.that I last saw her alive on *April 2*, 19*22*.and that death occurred, on the date stated above, at *7.30 A.m.*

The CAUSE OF DEATH\* was as follows:

*Cardiac dilation.*

(duration) yrs. mos. / ds.

CONTRIBUTORY (Secondary)

*Broncho - Pneumonia*

(duration) yrs. mos. / ds.

18 Where was disease contracted

if not at place of death?

*At home*

Did an operation precede death?

Date of

*no*

Was there an autopsy?

*no*

What test confirmed diagnosis?

(Signed *Ernest E. Galt*)

, M. D.

Address *Hebrew Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Hebrew Rose Dale April 2 1922*

20 UNDERTAKER

ADDRESS

*Jack Lewis 1439 E. Balt*

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Honswife*, *Honsework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63074

## CERTIFICATE OF DEATH.

179 D 63074  
REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2415 Maryland Avenue ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James V. McDivit

(a) RESIDENCE. No. 2415 Maryland Avenue ST. WARD.  
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24, 1866

7 AGE Years 55 Months 10 Days 7 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturers and

(b) General nature of industry, business, or establishment in which employed (or employer) Jobbers of Spices

(c) Name of employer and Teas

9 BIRTHPLACE (city or town) Adams' Co. Pennsylvania  
(State or country)

10 NAME OF FATHER Joseph P. McDivit

11 BIRTHPLACE OF FATHER (city or town) Adams Co. Pennsylvania  
(State or country)

12 MAIDEN NAME OF MOTHER Mary J. Diffendal

13 BIRTHPLACE OF MOTHER (city or town) Frederick Co. Maryland  
(State or country)14 Informant Dr. Harry N. McDivit  
(Address) 2 East 25th. Street

15 APR 2 - 1922 ROBERT R. KRAUTER Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1922

17 I HEREBY CERTIFY, That I attended deceased from 11 W. 27, 1921, to March 31, 1922,

that I last saw him alive on March 31, 1922,

and that death occurred, on the date stated above, at 5.30 A. M.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial nephritis

(duration) 5 yrs. -- mos. -- ds.

CONTRIBUTORY (Secondary) Uremia

(duration) 1 yrs. -- mos. -- ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary tests  
(Signed) George M. Smith, M. D.,

19 1922 Address 2435 Mayland Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Emmitsburg, Maryland

4/3, 1922

20 UNDERTAKER

ADDRESS

Henry W. Mears &amp; Son 805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Physicians should be stated EXACTLY. Exact statement of OCCASION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

D 63075 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 D 63075

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1723 E. Biddle ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary E. McAdow

(a) RESIDENCE NO.

1723 E. Biddle ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

44 yrs. 7 mos. 5 ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

(If non-resident give city or town and State)

ys.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White Widowed

5a If married, widowed, or divorced

(or) WIFE of

Jas. M. McAdow

6 DATE OF BIRTH (month, day, and year)

Nov 30, 1840

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

81

4

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Franky McAdow 1723 E. Biddle

15

APR 3 - 1922

ROBERT H. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 31 1922

17

I HEREBY CERTIFY, That I attended deceased from

Mar 26, 1922, to Mar 31, 1922,

that I last saw her alive on Mar 31, 1922,

and that death occurred, on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH\* was as follows:

Broncho-pneumonia

(duration)

ys.

mos.

5 ds.

CONTRIBUTORY (Secondary)

Fracture of fore arm

(duration)

ys.

mos.

6 ds.

18 Where was disease contracted

if not at place of death?

Place of death

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Visual tests

(Signed)

C. W. Macdonald, M. D.

April 1, 1922 (Address)

1540 N. Broadway

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-MOVAL

Baltimore

DATE OF BURIAL

April 3, 1922

20 UNDERTAKER

Jerkler & Jerkler

ADDRESS

1739 Eager

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name organ; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

Opinion of J. H. Jones, M.D.  
Had fall. then  
developed pneumonia  
Accidental fall on street

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 63076 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 D 63076  
CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 S. Curley. ST. 1 WARD)

2-FULL NAME

(Residence in Baltimore: No. 607 S. Curley St. St.; yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE  
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER  
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from Mar 9, 1922, to Mar 30, 1922,

that I saw him alive on Mar 30, 1922,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Valvular heart disease (Chronic)

(Duration) yrs. mos. ds.

Contributory  
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

Apr 2, 1922 [Address] 3211 Eastern Ave

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

21-

22-

ROBERT R. KRAUTER

APR 3-1922

REGISTRAR

Oak Lawn Cemetery Apr 3, 1922

John A. Moran 3000 E. Balto.



63077  
D 63077

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.: *44* WARD)

## 2-FULL NAME

(a) RESIDENCE. NO. *Churchtown, Md.* ST.:  WARD. 

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *1*mos. *12*ds. 

How long in U. S. If of foreign birth?

yrs. mos. ds. 

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years *58* Months  Days  If LESS than 1 day, hrs.  or min. 

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Virginia*10 NAME OF FATHER *Wm. Thompson*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Va*12 MAIDEN NAME OF MOTHER *Not known*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Va*

14

Informant (Address) *Hospital records*

15

APR 3 - 1922

ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 1* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

*2/19* 19 *22* to *4/1* 19 *22*that I last saw him alive on *3/31* 19 *22*and that death occurred, on the date stated above, at *12:20* *A.M.*

The CAUSE OF DEATH\* was as follows:

*Carcinoma of stomach involving transverse colon peritoneum & lymph nodes* (duration) *3* yrs.  mos.  ds. 

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of Was there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *W. B. Smith* M. D.Address *University Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Shad of Side, Md. Union - Apr 3 1922*

20 UNDERTAKER

ADDRESS *1303**James H. Dennis* *Chesapeake*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

D 63078

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2726 St Paul ST. 17 WARD)

## 2-FULL NAME

Margaret Hester Johnson

## (a) RESIDENCE. NO.

2726 St Paul St. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Widowed

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofElbridge S. Johnson

## 6 DATE OF BIRTH (month, day, and year)

Aug. 18, 1846

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.75813

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

✓

(c) Name of employer

✓9 BIRTHPLACE (city or town)  
(State or country)East New Market Ind

## 10 NAME OF FATHER

John Lucchesi

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Dorchester Co. Ind

## 12 MAIDEN NAME OF MOTHER

Rebecca Simmons

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Dorchester Co. Ind

## 14

Informant  
(Address)Sister Mrs R H Stevens  
2726 St Paul St

## 15

APR 3 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 192217 I HEREBY CERTIFY That I attended deceased 9:15 a.m.April 1, 1922, to April 1, 1922that I last saw her alive on April 1, 1922and that death occurred, on the date stated above, at 9:15 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage  
causing coma &  
complete Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)Chronic Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted  
If not at place of death?✓Did an operation precede death? no Date of ✓Was there an autopsy? noWhat test confirmed diagnosis? ✓(Signed) Jefferson B. Buckle, D.1922 Address 2844 St Paul St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Secretary Ind.April 3, 1922

20 UNDERTAKER

George J. Smith

ADDRESS

1000 25th St

D 63079

## HEALTH DEPARTMENT—CITY OF BALTIMORE

63079

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *402 Francis* ST. *13* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. No. *402 Francis* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 27/22*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *one 3*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto.* (State or country)10 NAME OF FATHER *Mr. Schaeff*11 BIRTHPLACE OF FATHER (city or town) *Ger.* (State or country)12 MAIDEN NAME OF MOTHER *Marie Lang*13 BIRTHPLACE OF MOTHER (city or town) *Ger.* (State or country)14 Informant *Mr. Marie Schaeff* (Address) *402 Francis St.*15 Filed *ROBERT R. KRAUTER,*

Registrar

Burial Permit Clerk,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 27/22*17 I HEREBY CERTIFY, That I attended deceased from *Mar 30th 22* to *Apr. 24th 22* that I last saw him alive on *Apr. 1st 22*and that death occurred, on the date stated above, at *1200* m.

The CAUSE OF DEATH\* was as follows:

*Lactipia T. Caed*  
*Very small weak baby*  
*from birth*(duration) yrs. mos. ds. *3*CONTRIBUTORY (Secondary) *Weakness, undeveloped*  
*bone med. or nervous system*  
(duration) yrs. mos. ds. *2*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Visible*(Signed) *Edmund* M. D.*4/2, 1922* (Address) *1005 N. North Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Western Cemetery* *Apr 3 1922*

20 UNDERTAKER ADDRESS

*Joseph Sefer 1600 N. North Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PR 3 - 1922

D 63080

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2120 E. Fayette ST., 6 WARD)

## 2-FULL NAME

Charles Cohen

## (a) RESIDENCE NO.

2120 E. Fayette

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. — mos. — ds. How long in U. S., if of foreign birth? 48 yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Lottie Cohen6 DATE OF BIRTH (month, day, and year) April 14-18617 AGE Years 60 Months 11 Days 28 If LESS than 1 day, — hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Merchant Sailor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Solomon Cohen

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Sarah Baschke

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant

(Address)

Lottie Cohen  
2120 E. Fayette St

15

APR 3 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 11 1922 to Apr 2 1922.that I last saw him alive on Apr 2 1922.and that death occurred, on the date stated above, at 1:50 P. M.

The CAUSE OF DEATH\* was as follows:

Acute Cardiac DilatationCONTRIBUTORY (duration) Chronic Bronchitis 2 yrs. 2 mos. 2 ds.  
(Secondary) Chronic Myocarditis over 2 mos. 2 ds.18 Where was disease contracted if not at place of death? ✓Did an operation precede death? ✓ Date of ✓Was there an autopsy? ✓What test confirmed diagnosis? Physical Examination(Signed) Harry S. Hale M. D.Date Apr 2 1922 (Address) 1203 E. Fayette St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAD

Baldwin Cern.

20 UNDERTAKER

David Sondheim 1180 Mt. Royal Ave.

DATE OF BURIAL

4/3 1922

ADDRESS



D 63081

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

51 D 63081

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 N. Mountford ST., 8 WARD)

2. FULL NAME Mary Isabelle Holmes

(a) RESIDENCE NO. 1113 N. Mountford ST.,

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Francis L. Holmes

6 DATE OF BIRTH (month, day, and year) Mar 6, 1891

7 AGE Years 30 Months 4 Days 25 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md

10 NAME OF FATHER Geo W Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER Mary W Bunnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Francis L. Holmes 1113 N. Mountford Ave

15

Filed

19

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1922

17 HEREBY CERTIFY, That I attended deceased from Mar. 23, 1922, to Apr. 1, 1922,

that I last saw her alive on Mar. 31, 1922, and that death occurred, on the date stated above, at 6:30 A. M.

The CAUSE OF DEATH\* was as follows:

Acute Myocarditis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

yo

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. H. H. M. D.

19 (Address) 1340 N. Mountford Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Green Park

DATE OF BURIAL

Apr 7, 1922

20 UNDERTAKER

H. W. Conner

ADDRESS

1113 N. Mountford Ave

APR 3 - 1922

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 63082

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

St. Raphaels

Registered No. C.....

City of BALTIMORE: (No. 509 Hanover St. St. 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Shirley I. Hale.

(Residence in Baltimore: No. St. Raphaels 509 Hanover St. St. 22; yrs. 10 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female. 4-COLOR OR RACE White. 5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH May 7th 1921. (Month) (Day) (Year)

7-AGE 10 yrs. 25 mos. 25 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work None. (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or Country) Baltimore, Md.

10-NAME OF FATHER Louis Hale.

11-BIRTHPLACE OF FATHER (State or Country) Atlanta, Ga.

12-MAIDEN NAME OF MOTHER Clara Stortz.

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara Hale. (mother)

(Address) 2351 Taylor Ave.

APR 3 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH April 1st 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Mitral Insufficiency congenital.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D. (Coroner)

April 2 1922 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Manner of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20-UNDERTAKER ADDRESS

Johnnie Handes 946 Wisconsin St.

D 63083

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

ST. 24 WARD)

## 2-FULL NAME

(a) RESIDENCE. NO.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

APR 3 - 1922

ROBERT R. KRAUTER

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 1 - 1922

17

I HEREBY CERTIFY, That I attended deceased from Mar. 31, 1922, to Apr. 1, 1922,

that I last saw her alive on Mar. 31, 1922,

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH\* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

J. M. Delivett, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63084

D 63084

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital

ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Harrod

(a) RESIDENCE. No. 402 E. 22<sup>1</sup>/<sub>2</sub> St.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE 61 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Janitor 070

(b) General nature of industry, business, or establishment in which employed (or employer)

Janitor

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co., Maryland

10 NAME OF FATHER John E. Harrod

11 BIRTHPLACE OF FATHER (city or town) Calvert Co., Maryland

12 MAIDEN NAME OF MOTHER Susan Butter

13 BIRTHPLACE OF MOTHER (city or town) St. Mary's Maryland

14 Informant Hospital Records, Municipal Hospital.

15 APR 3 - 1922 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 19 22

17 I HEREBY CERTIFY, That I attended deceased from March 14 19 22, to March 31 19 22 that I last saw him alive on March 31 19 22 and that death occurred, on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH\* was as follows:

Infected varicose ulcers of left leg -

(duration) yrs. 19 mos. ds.

CONTRIBUTORY (Secondary)

Pulmonary edema

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3-27-22

Was there an autopsy? no

What test confirmed diagnosis?

Clinical findings  
(Signed) L. H. Brumback M. D.

4/1/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Laurel Cemetery

DATE OF BURIAL

Apr 3 19 22

20 UNDERTAKER

Mrs Robert A. Elliott

ADDRESS 1725

Ashland



D 63085

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

D 63085

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1504 W. Fannin St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Fannie Johnson

## (a) RESIDENCE. No.

1504 W. Fannin St. 19 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

Col

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Howard Johnson

## 6 DATE OF BIRTH (month, day, and year)

Feb 18-1883

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

39

1

13

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Landress 041

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Va

## 10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Va

## 12 MAIDEN NAME OF MOTHER

Janie Falcia

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Va

## 14

Informant

(Address)

Gertrude Biddle  
1004 W. Fannin St.

## 15

Filed

APR 3-1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Apr 1 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Mar 25 1922 to Apr 1 1922

that I last saw him alive on Apr 1 1922

and that death occurred, on the date stated above, at 2.30 P. M.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY  
(Secondary)

(duration) — yrs. — mos. — ds.

## 18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

F. C. Loick M. D.  
1313 W. North St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Mt Auburn Cem.

April 4th 1922

## 20 UNDERTAKER

## ADDRESS

A. Jones

207 S. St. Louis

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

63086 P. Co.—1000 Bks.

Nobel B Edwards  
HEALTH DEPARTMENT—CITY OF BALTIMORE

63086

CERTIFICATE OF DEATH.

1-PLACE OF DEATH, Volunteer of America, 740p.  
CITY OF BALTIMORE: (No. 418 W. Lexington ST.: 18 WARD)

REGISTERED NO. ....  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nobel B. Edwards

(a) RESIDENCE. No. 1240 W. Pratt ST.,  
(Usual place of abode)

WARD. ....  
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 41 Years Months Days If LESS than 1 day. hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

Jobbing

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore City

10 NAME OF FATHER

Jobe H. Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Suffolk, Va

12 MAIDEN NAME OF MOTHER

Hannah Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Philadelphia Pa

14

Informant (Address)

Hannah Edwards  
1240 W. Pratt St.

15

APR 3 - 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1922

17 I HEREBY CERTIFY, That I attended deceased from

March 30, 1922, to March 30, 1922,

that I last saw him alive on March 30, 1922,

and that death occurred, on the date stated above, at 7:30 p. m.

The CAUSE OF DEATH\* was as follows:

chronic interstitial nephritis

(duration) 2 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

Lab. Pain in groin - 10 days

18 Where was disease contracted if not at place of death? 1240 W. Pratt St.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical signs

(Signed) J. L. Bayardel, M. D.

19 (Address) 418 W. Lexington St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

National Cem

April 30 1922

20 UNDERTAKER

A. Jones

ADDRESS

207 S. Street

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63087

## CERTIFICATE OF DEATH.

57 D 63087  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3608 Park Heights Ave* ST., *15* WARD)

## 2-FULL NAME

*Mary E Meusel*

## (a) RESIDENCE NO.

*3608 Park Heights Ave* ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *59* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Female**White**Married*6a-~~Married, widowed, or divorced~~

(or) WIFE of

*Henry H Meusel*6 DATE OF BIRTH (month, day, and year) *June 4<sup>th</sup> 1863*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*59**9**27*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md*

## 10 NAME OF FATHER

*Geo Dukehart*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Baltimore Md*

## 12 MAIDEN NAME OF MOTHER

*Caroline King*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*

## 14

Informant

(Address)

*Henry H. Meusel (Husband)*  
*3608 Park Heights Ave*

## 15

*APR 3 - 1922*

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 31<sup>st</sup> 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*Mar. 9, 1922* to *Mar. 31, 1922*that I last saw him alive on *Mar. 9, 1922*and that death occurred, on the date stated above, at *10:15 A* m.

The CAUSE OF DEATH\* was as follows:

*Uraemic Convulsions**(Diabetes mellitus)*(duration) yrs. mos. ds. *1 hr*

## CONTRIBUTORY (Secondary)

*Chronic Intestinal*  
*Nephritis* 2 yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *James S. Adelman*, M. D.4-1, 1922 (Address) *4014 Park Heights Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

*Baltimore Cem.* *4-3 1922*

## 20 UNDERTAKER

## ADDRESS

*Mrs Chas A G Rohde* *600 N. Arlington Ave*

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D 63088  
PLACE OF DEATH

CITY OF BALTIMORE: (No. 1403 Holbrook St., 9 WARD)

2-FULL NAME

Marie Zimmerman

(a) RESIDENCE NO.

1403 Holbrook

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? 45 yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed or divorced

HUSBAND of  
(or) WIFE of

Charles Zimmerman

6 DATE OF BIRTH (month, day, and year)

Sept 28, 1857

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

64

6

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Germany

10 NAME OF FATHER

Mr. Yeager

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Not Known

14

Informant  
(Address)Mr. Charles Zimmerman  
1403 Holbrook St.

15

Filed

APR 3 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 2, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 31, 1922, to April 2, 1922

that I last saw him alive on April 1, 1922

and that death occurred, on the date stated above, at 1:30 A. M.

The CAUSE OF DEATH\* was as follows:

Mitral regurgitation

(duration) yrs. 3 mos. 3 ds.

CONTRIBUTORY  
(Secondary)Acute cardiac  
degeneration (duration) yrs. 3 mos. 3 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

no

Date of none

Was there an autopsy?

no

What test confirmed diagnosis?

none

(Signed) J. F. Yeager, M. D.

42, 1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Baltimore Cemetery

Apr. 4 1922

20 UNDERTAKER

ADDRESS

Henry Stock Sons

1301 E. Bay St.

Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



nation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21-M&T-1500 Bks.

63089

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 Aisquith ST. 2 WARD)

2-FULL NAME

(a) RESIDENCE NO. 231 Aisquith ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE Years 61 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

APR 3 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1922

17

I HEREBY CERTIFY, That I attended deceased from March 24, 1922, to April 2, 1922,

that I last saw him alive on April 2, 1922,

and that death occurred, on the date stated above, at 7:30 A. M.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed)

4/2, 1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Bethel Memorial

4/3 1922

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E. Baltimore

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63090

D 63090

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1007 Cathedral ST., 11 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Dr. Henry B. Thomas

## (a) RESIDENCE NO.

1007 Cathedral

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofHelen G. Coyle Thomas

6 DATE OF BIRTH (month, day, and year)

Apr 16, 1864

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.5711

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Physician 154

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Deep Falls  
St. Mary's Co. Md.

10 NAME OF FATHER

James Q. Thomas

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

St. Mary's Co. Md.

12 MAIDEN NAME OF MOTHER

Jeannette C. Busch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

St. Mary's Co. Md.

14

Informant  
(Address)Henry B. Thomas, Jr.1007 Cathedral St.

15

APR 3 - 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 2, 1922

17

I HEREBY CERTIFY, That I attended deceased from

April 2, 1922, to April 2, 1922that I last saw him alive on April 2, 1922and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH\* was as follows:

Tubercular  
mid attack of pneumonia  
(duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)Physical fatigue  
(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

Chinical history  
(Signed) B. B. Thomas M. D.

(Address)

1007 Cathedral

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Louder Park April 4, 1922John O. Mitchell 1201 W. Fayette

mation should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63091

## CERTIFICATE OF DEATH.

REGISTERED No. C

D 63091

### 1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Hopkins Hospital* ST. WARD)

### 2-FULL NAME

*Wilhelm Hagemeyer*

(Residence in Baltimore: No. *300 N. Robinson St.*)

Sp.; yrs., *7* mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married*  
(Write the word.)

6-DATE OF BIRTH, *Feb. 5*, *1892*  
(Month) (Day) (Year)

7-AGE, *30* yrs., *1* mo., *25* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work *house*  
(b) General nature of industry, business, or establishment in which employed (or employer) *300*

9-BIRTHPLACE (State or Country) *Germany*

10-NAME OF FATHER *Gottlieb Hagemeyer*

11-BIRTHPLACE OF FATHER (State or Country) *Germany*

12-MAIDEN NAME OF MOTHER *Huber*

13-BIRTHPLACE OF MOTHER (State or Country) *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

*Mrs. Wm. Hagemeyer*  
*300 N. Robinson St.*  
(Address)

15-APR 3 - 1922 ROBERT R. KRAUTER,

Filed *191* *Burial Permit* *Clerk*

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *Apr. 30*, *1922*  
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *Examiner*  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest*  
(Inquest, au-

*Inquest* and that said deceased came to *death*  
(Inquest, au-

topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH was as follows:

*Fracture of hip by*  
*fall*  
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) *Stomach Insult*  
(Duration) ... yrs. ... mos. ... ds.

(Signed) *John Insler* M. D.

*5-31, 1922* (Address) *48 N. ...*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, *Oakland Cem.* DATE OF BURIAL, *Apr. 30*, *1922*

20-UNDERTAKER *Joseph B. Cook* ADDRESS *1003 N. Baltimore St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63092

## CERTIFICATE OF DEATH.

D 63092

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2812 Raynor Ave. ST. 16 WARD)

## 2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

2812 Raynor Ave

ST.

WARD

47 yrs. 2 mos. 27 ds.

(If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of

Ernest E. Jackson

6 DATE OF BIRTH (month, day, and year)

Jan 4 1875

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

47

2

27

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 137

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

William H. Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Md.

12 MAIDEN NAME OF MOTHER

Bridget Nolan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Chelmsford

14

Informant (Address)

Ernest E. Jackson 2812 Raynor Ave

15

APR 3 - 1922

ROBERT H. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 31<sup>st</sup> 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1921, to March 31, 1922, that I last saw her alive on March 31, 1922, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH\* was as follows:

Apoplexy Haemorrhage of Lung. Tuberculosis

CONTRIBUTORY (Secondary)

+ Lung

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

331, 1922

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

Mt Olivet

20 UNDERTAKER

Jas B. Cook

DATE OF BURIAL

April 3, 1922

ADDRESS

103 N. Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



D 63093 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 63093

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 Morris

ST., 11 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Michael Donoghue

## (a) RESIDENCE NO.

202 Morris

ST., 11 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 10 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married.

## 5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Lilla Donoghue

## 6 DATE OF BIRTH (month, day, and year)

May 15th, 1879

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
51 10 18

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Boilermaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. &amp; O. R.R.

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

## 10 NAME OF FATHER Michael Donoghue

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

## 12 MAIDEN NAME OF MOTHER Anne Connolly

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

## 14 Informant (Address)

Mrs. George Brennan  
1025 Hollins Street.

## 15 File

APR 3 - 1922

ROBERT R. KRAUTER  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 2<sup>nd</sup> 1922

## 17 I HEREBY CERTIFY, That I attended deceased from

3/25, 1922, to 4/2/22, 1922.

That I last saw him alive on 4/1/22, 1922.

and that death occurred, on the date stated above, at 1:20 A. M.

The CAUSE OF DEATH\* was as follows:

Cardiac exhaustion

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) ? (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? none

What test confirmed diagnosis? none

(Signed) J. M. Sullivan M. D.

1922 (Address) 302 N. Paulina

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral Co. Apr. 5, 1922

## 20 UNDERTAKER

Joseph D. Cook 1003 N. Paulina

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63094

## CERTIFICATE OF DEATH.

88 D 63094

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 E. 28th ST., 9 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Osabell D Furst

## (a) RESIDENCE NO.

1607 E 28th

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 3 mos. 14 ds. How long in U. S., if of foreign birth? 5 yrs. 5 mos. 14 ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

Female WhiteSingle

## 5a If married, widowed, or divorced

Widowed6 DATE OF BIRTH (month, day, and year) Dec 17th 1916

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.5316

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

## 10 NAME OF FATHER

Frank M Furst

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

## 12 MAIDEN NAME OF MOTHER

Elizabeth Seiff

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

## 14

Informant (Address)

Frank M. Furst  
1607 E 28th St

APR 3 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 - 1922

## 17

I HEREBY CERTIFY, That I attended deceased from March 24, 1922, to April 2, 1922, that I last saw him alive on April 1, 1922, and that death occurred, on the date stated above, at 230 a. m.

The CAUSE OF DEATH\* was as follows:

acute arthritis

(duration)

yrs.

mos.

ds.

## CONTRIBUTORY (Secondary)

Endocarditis

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death? at homeDid an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

Young Waltham, M. D.Address 1615 Goldsboro Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

Parkwood Cemetery

## 20 UNDERTAKER

George Schilling & Sons

## DATE OF BURIAL

April 4th 1922

## ADDRESS

1126 E. Monument St

nation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *letanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

April 2, 1922  
Diagnosis confirmed  
by Red Cross  
by myself and two Consulting  
Physicians  
  
H. J. [Signature]

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63095

## CERTIFICATE OF DEATH.

D 63095  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1318 Homewood Ave 9 WARD)2-FULL NAME Virginia Quinn(a) RESIDENCE NO. 1318 Homewood Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of none6 DATE OF BIRTH (month, day, and year) June 3 19207 AGE Years 1 Months 9 Days 29 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none(b) General nature of industry, business, or establishment in which employed (or employer) none(c) Name of employer none9 BIRTHPLACE (city or town) Bald City (State or country)10 NAME OF FATHER George Quinn11 BIRTHPLACE OF FATHER (city or town) Bald City (State or country)12 MAIDEN NAME OF MOTHER Helen Manning13 BIRTHPLACE OF MOTHER (city or town) Bald City (State or country)14 Informant George Quinn (Address) 1318 Homewood Ave15 Filed APR 3 - 1922 19 ROBERT R. KRAUTER Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 192217 I HEREBY CERTIFY, That I attended deceased from March 28, 1922, to April 2, 1922, that I last saw her alive on April 1, 1922, and that death occurred, on the date stated above, at 11:15 m.

The CAUSE OF DEATH was as follows:

Double Lobar Pneumonia(duration) yrs. mos. 6 ds.CONTRIBUTORY Measles (Secondary)(duration) yrs. mos. 15 ds.18 Where was disease contracted 1318 Homewood Ave If not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? clinical(Signed) James M. Keenan M. D.4/2/1922 (Address) 200 E. Chestnut

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Cemetery April 3 1922

20 UNDERTAKER

ADDRESS

E. J. Manning & Son 1938 E. Lafayette Ave.

Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63096

## CERTIFICATE OF DEATH.

D 63096

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3921 Mt. Pleasant Ave ST., 76 WARD)

## 2. FULL NAME

Frances Blum.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

3921 Mt. Pleasant Ave ST.,

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married.

## 5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of Thomas Blum.6 DATE OF BIRTH (month, day, and year) Dec. 15 1859

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.62317

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at home 037

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Germany.10 NAME OF FATHER Andrew B. Burkhardt.

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

## 14

Informant  
(Address)Thomas Blum.  
3921 Mt. Pleasant Ave

15 APR 3 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 1 1922

## 17

I HEREBY CERTIFY, That I attended deceased from  
Feb. 21, 1922, to April 1, 1922  
that I last saw her alive on April 1, 1922  
and that death occurred, on the date stated above, at 12.30 P. m.  
The CAUSE OF DEATH\* was as follows:

Chronic Pancreatic Nephritis(duration) yrs. 6 mos. ds.CONTRIBUTORY  
(Secondary)(duration) yrs. 4 mos. ds.

## 18 Where was disease contracted if not at place of death?

at home

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Physician's report

(Signed)

19 (Address)

Chas. J. Keen, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

St. Stanislaus Cem.  
Lilly and Zeller.April 4 1922  
4038 N. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63097 Co.—1900 Bks.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63097

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 7<sup>th</sup> Broadway ST.: 8 WARD)

## 2-FULL NAME

George F Dixon(a) RESIDENCE. NO. 1401 Broadway ST.: 8 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced, name of HUSBAND or WIFE Edna F Dixon6 DATE OF BIRTH (month, day, and year) Oct 1 1921 7 AGE Years 47 Months — Days — If LESS than 1 day, hrs. — or min. —

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Custor9 BIRTHPLACE (city or town) Quebec (State or country)10 NAME OF FATHER Geo F Dixon11 BIRTHPLACE OF FATHER (city or town) N.Y. (State or country)12 MAIDEN NAME OF MOTHER Leah Farnham13 BIRTHPLACE OF MOTHER (city or town) N.Y. (State or country)14 Informant Edna F Dixon (Address) 1401 7<sup>th</sup> Broadway15 Registrar ROBERT R. KRAUER Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 2/22 1917 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1921, to Apr 2, 1922, that I last saw him alive on Apr 1, 1922, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH\* was as follows:

Arterio-sclerosis—  
myocarditis—  
parenchymatous nephritis  
about 2 yrs  
(duration) yrs. mos. ds.CONTRIBUTORY (Secondary) Diabetes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? physical(Signed) W.S. Keblatt M. D.  
(Address) 2220 Garrison Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Prots Cemetery

20 UNDERTAKER

Robt Johnson

DATE OF BURIAL

Apr 4 1922

ADDRESS

1401 7<sup>th</sup> Broadway

See instructions on back of certificates. See instructions on back of certificates.

D 63098

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31<sup>D</sup> 63098

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No Municipal Tuberculosis Hospital WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bulgen(a) RESIDENCE. NO. 1106 Ridgley st.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	widow

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Not stated

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day. hrs. or min.
	45			

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington  
(State or country) D.C.10 NAME OF FATHER John Dengel11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Unknown12 MAIDEN NAME OF MOTHER Nettie Fay13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Unknown14 Informant Hospital Records  
(Address) M.T.H.15 Filed APR 3 - 1922 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1922

17 I HEREBY CERTIFY, That I attended deceased from  
March 25, 1922, to March 31, 1922.  
that I last saw her alive on March 31, 1922.  
and that death occurred, on the date stated above, at 5.50 p. m.  
The CAUSE OF DEATH\* was as follows:

pulmonary tuberculosis(duration) yrs. 8 mos. ds.CONTRIBUTORY Chronic myocarditis  
(Secondary)(duration) Unknown mos. ds.18 Where was disease contracted  
if not at place of death? UnknownDid an operation precede death? NO Date ofWas there an autopsy? NOWhat test confirmed diagnosis T. B. in sputum(Signed) Francis L. Badalozzi M. D.-1-22 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

New Cathedral Cemetery April 5, 1922

20 UNDERTAKER

James Dignan & Son 1600 S. Paca

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63099

## CERTIFICATE OF DEATH.

REGISTERED NO. C

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 W. Lee ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### 2-FULL NAME

Baby Brown

(Residence in Baltimore: No. 20 W. Lee St.; ..... yrs., ..... mos. ..... ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

#### 3-SEX

F

#### 4-COLOR OR RACE

W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

#### 6-DATE OF BIRTH

3 31, 1922  
(Month) (Day) (Year)

#### 7-AGE

0 yrs. 0 mos. 0 ds.

If LESS than 1 day, .... hrs. or. 10 min.

#### 8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Infant  
000

#### 9-BIRTHPLACE (State or Country),

Balt Md

#### 10-NAME OF FATHER

Arthur Brown

#### 11-BIRTHPLACE OF FATHER (State or Country),

Va

#### 12-MAIDEN NAME OF MOTHER

Gertrude Marie Wahl

#### 13-BIRTHPLACE OF MOTHER (State or Country),

Md

### 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helena res. Evans

(Address) 3 Balt Hosp

#### 15-

Filed 101 APR 3 1922

APR 3 - 1922

Registrar.

Commissioner Health

19063

### MEDICAL CERTIFICATE OF DEATH.

#### 16-DATE OF DEATH

3 31, 1922  
(Month) (Day) (Year)

#### 17- I HEREBY CERTIFY, That I attended deceased from

March 31 1922, to March 31 1922,

that I saw her alive on March 31 1922,

and that death occurred, on the date stated above, at 2.25 p.m.

The CAUSE OF DEATH\* was as follows:

Prematurity

(Duration) ..... yrs. .... mos. .... ds.

#### CONTRIBUTORY (Secondary)

(Duration) ..... yrs. .... mos. .... ds.

(Signed) Susan R. Parnes M. D.

5-31, 22 (Address) Thurmond

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

#### 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

#### 19-PLACE OF BURIAL OR REMOVAL,

#### DATE OF BURIAL,

....., 1922

#### 20-UNDERTAKER

#### ADDRESS

1922  
APR 1

Pop. Wm. K. FOSSELL



154853 HEALTH DEPARTMENT—CITY OF BALTIMORE  
D 63100

D 63100

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST. 8 WARD)

## 2. FULL NAME

Hortense Watson

## (a) RESIDENCE NO.

1929 East Biddle St.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Unknown

How long in U. S. if of foreign birth?

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female Colored Single

## 4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

## 5a If married, widowed, or divorced

Married Carrie Watson, mother

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Baby 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Balto.

## 10 NAME OF FATHER

Made Louise

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa.

## 12 MAIDEN NAME OF MOTHER

Carrie Watson

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa.

## 14

Informant (Address)

JOHNS HOPKINS HOSPITAL

## 15

APR 3 - 1922 ROBERT R. KRAUTER Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

March 31, 1922

## 17

HEREBY CERTIFY, That I attended deceased from

March 29, 1922 to March 31, 1922

that I last saw her alive on March 31, 1922

and that death occurred, on the date stated above, at 9:00 A. M.

The CAUSE OF DEATH\* was as follows:

Early hereditary syphilis

(duration)

yrs.

mos

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos

ds.

## 18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Wright & Wassermann

(Signed) Horace G. Stewart M. D.

3/31, 1922 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

1922

## 20 UNDERTAKER

## ADDRESS

Commissioner Health

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63101

## CERTIFICATE OF DEATH.

D 63101

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal HospitalST.: 26 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maurice Budde(a) RESIDENCE. No. Bay View Alms HouseST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Unknown

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE

70

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Hospital Records,

Municipal Hospital.

15

Filed

APR 3 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 19 22

17

I HEREBY CERTIFY, That I attended deceased from March 31, 19 11, to March 29, 19 22, that I last saw him alive on March 29, 19 22, and that death occurred, on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH\* was as follows:

*Myocardial Insufficiency*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) *Clayton McNeill*

M. D.

3/31/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

19

JAMES M. KRAUTER

APR 1 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -1-10-21-M&T-1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE  
D 63102

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bay View Hospital

CITY OF BALTIMORE: No.

ST.

WARD

2-FULL NAME

Alance Nugent

(a) RESIDENCE No.

(Usual place of abode)

Length of residence in city or town where death occurred

ST.

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,

Divorced, (write the word)

Male Black, Married

6a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1890?

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

32?

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Unknown

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

087

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

West Indies

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Do

12 MAIDEN NAME OF MOTHER

Do

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Do

14

Informant  
(Address)

Bay View Hospital

15

APR 3 - 1922

Burial Permit Clerk

Registrar

REGISTERED NO.

(If death occurred in  
a hospital or institution,  
give its NAME  
instead of street and  
number.)

38

D 63102

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 28, 1922

17

I HEREBY CERTIFY, that I attended deceased from

March 28, 1922, March 28, 1922,

that I last saw him alive on March 27, 1922,

and that death occurred, on the date stated above, at 4:20 a.m.

The CAUSE OF DEATH\* was as follows:

Acute Spinal Les.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

Septic Infection

18 Where was disease contracted  
if not at place of death?

Unknown

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

N. Fredson

3/29/1922 (Address)

Bay View Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

UNIVERSITY OF MARYLAND.

20 UNDERTAKER

Commissioner Health

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63103

## D 63103 CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (Municipal Tuberculosis Hospital) WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arcelia Jernigan

(a) RESIDENCE. No. 428 N. Central ave. ST. WARD.  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female Colored Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
24

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Ulus Jernigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mamie Boyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Hospital Records  
(Address) M.T.H.15 APR 3 - 1922 ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1922

17 I HEREBY CERTIFY, That I attended deceased from October 14, 1921, to March 31, 1922, that I last saw her alive on March 31, 1922, and that death occurred, on the date stated above, at 5.30 a. m. The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY Tuberculous enteritis  
(Secondary)

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray  
(Signed) Francis L. Sabatelli, M.D.

3-31-22 Address Municipal Tbc. Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

CITY OF MARYLAND

20 UNDERTAKER  
J. M. B. B. B.

ADDRESS

APR 3 1922



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63104

## CERTIFICATE OF DEATH.

90 D 63104

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal HospitalST.: 76 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Matthews(a) RESIDENCE. No. Bay View Asylum

ST..

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofUnknown

6 DATE OF BIRTH (month, day, and year)

1864

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.57----

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

Unknown

(State or country)

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

Unknown

(State or country)

14

Informant  
(Address)Hospital Records,Municipal Hospital.

15

File

APR 3 - 1922ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 19 22

17

I HEREBY CERTIFY, That I attended deceased from  
August 27, 19 19, to March 31, 19 22,  
that I last saw him alive on March 31, 19 22,  
and that death occurred, on the date stated above, at 3:00 P. m.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency  
(duration) 1 yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

Clyde M. Meneil

M. D.

4/3/22 Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

CITY OF MARYLAND

20 UNDERTAKER

Commissioner Health

ADDRESS

APR 3 1922

D 63105

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 63105

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Nebragoed Home for Children* ST., *47* WARD)2. FULL NAME *IDA Kaminskawich*(a) RESIDENCE NO. *1520 E. Lombard St.* ST., *47* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *16* yrs. mos. ds. How long in U. S., if of foreign birth? *16* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of *Harris Kaminskawich* or) WIFE of6 DATE OF BIRTH (month, day, and year) *April 2, 1922*7 AGE Years *41* Months *—* Days *—* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Russia* (State or country)10 NAME OF FATHER *Morris Stobuck*11 BIRTHPLACE OF FATHER (city or town) *Russia* (State or country)12 MAIDEN NAME OF MOTHER *Anna*13 BIRTHPLACE OF MOTHER (city or town) *Russia* (State or country)14 Informant *Jack Lewis* (Address) *1439 E. Balto St.*15 *APR 3 - 1922* ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 8, 1922*17 I HEREBY CERTIFY, That I attended deceased from *December, 1921* to *April 2, 1922*, that I last saw him alive on *April 2, 1922*, and that death occurred, on the date stated above, at *69* m.The CAUSE OF DEATH\* was as follows: *carcinoma of breast with metastases*(duration) *1* yrs. *6* mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *March 15*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Samuel Whitcomb M. D.*19 (Address) *1392 W. Lombard St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Green Wash. Road**4-3-22*

20 UNDERTAKER

ADDRESS

*Jack Lewis**1439 E. Balto*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR- TION is very important. See instructions on back of certificates.

D 63106

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

63106

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1718 N. Washington St.* WARD *8*)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Peter Armiger*(a) RESIDENCE NO. *1718 N. Washington St.* WARD *8*

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Widowed*

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

*Hose Armiger*6 DATE OF BIRTH (month, day, and year) *Oct 23 1852*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*70**5*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*

10 NAME OF FATHER

*Joseph Armiger*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*England*

12 MAIDEN NAME OF MOTHER

*August Wynn*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Stoan*

14

Informant (Address)

*John M. Armiger 1718 N. Washington St.*

15

APR 3 - 1922

ROBERT R. KRAUTER,

Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 2 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar 31 1922 to April 2 1922*that I last saw him alive on *April 2 1922*and that death occurred, on the date stated above, at *9 a.m.*

The CAUSE OF DEATH\* was as follows:

*Brain pneumonia*

(duration)

yrs.

mos.

da.

CONTRIBUTORY (Secondary)

*acute Cardiac dilatation*

(duration)

yrs.

mos.

da.

18 Where was disease contracted

if not at place of death?

*unknown*

Did an operation precede death?

*No* Date of *—*

Was there an autopsy?

*No*

What test confirmed diagnosis?

*findings*

(Signed)

*F. F. R. M. D.*

4-2-22

(Address)

*100 N. Pratt St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Holy Redeemer Ch.**April 4 1922*

20 UNDERTAKER

ADDRESS

*Frank Q. Pink 915 N. Gay*

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63107

## CERTIFICATE OF DEATH.

REGISTERED No. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 N. Bruce St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Louise Burley(Residence in Baltimore: No. 310 N. Bruce St. St.; 9 yrs., 8 mos., 8 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female4-COLOR OR RACE Col5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single6-DATE OF BIRTH, June 24, 1921

(Month)

(Day)

(Year)

7-AGE, 9 yrs., 8 mos., 8 ds.

If LESS than 1 day, ....hrs. or ....min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), MD10-NAME OF FATHER, Richard Burley11-BIRTHPLACE OF FATHER (State or Country), MD12-MAIDEN NAME OF MOTHER Mary E. Butler13-BIRTHPLACE OF MOTHER (State or Country), MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Burley(Address) 310 N. Bruce

15-

ROBERT R. KRAUTER,

APR 3 1922

Burial Form

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 1st, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from March 28, 1922, to April 1st, 1922, that I saw him alive on April 1st, 1922, and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH\* was as follows:

Bronchopneumonia(Duration) 4 yrs., 4 mos., 21 ds.CONTRIBUTORY (Secondary) Acute Bronchitis(Duration) 4 yrs., 4 mos., 21 ds.(Signed) J. H. Hays M. D.471....., 101..... (Address) 513 N. Calver St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, McAuburnDATE OF BURIAL, Apr. 3, 192220-UNDEBTAKER Sam'l H. ChaseADDRESS 400 N. Calver

CAUSE OF DEATH in plain terms so that it may be properly translated. State statement of occupation if any. important. See instructions on back of certificate.



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-  
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63108

CERTIFICATE OF DEATH.

90 D 63108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Arthur

(a) RESIDENCE No. Unknown

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE Years Months Days If LESS than 1 day. hrs. or min. 65 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co.,  
(State or country) Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown  
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)

14 Informant Hospital Records,  
(Address) Municipal Hospital.

15 Filed APR 3 - 1922 19 ROBERT R. KRAUTER  
Registrar  
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1922

17 I HEREBY CERTIFY, That I attended deceased from November 23, 1921, to April 1, 1922.  
that I last saw him alive on April 1, 1922.  
and that death occurred, on the date stated above, at 4:50 P.M.  
The CAUSE OF DEATH\* was as follows:

Myocardial insufficiency

CONTRIBUTORY (duration) yrs. mos. ds. Coronary sclerosis,  
(secondary) patent (duration) 20 yrs. mos. ds.

18 Where was disease contracted?  
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeill M. D.

4/3/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

At Auburn

4/3/22

20 UNDERTAKER

ADDRESS

Sam. W. Chase

1406

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63109

D 63109

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Municipality Hospital

CITY OF BALTIMORE: (No.

Lambert &amp; Greene

ST.

WARD)

2-FULL NAME

Albert L. Williams

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

107 W. Conway

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

12 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1865

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

57

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Mass.

10 NAME OF FATHER

Lucas B. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Mass.

12 MAIDEN NAME OF MOTHER

Margaret Warden

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Mass.

14

Informant (Address)

Stephen Records

15

Robert F. Harrison,

19

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/2 1922

17

I HEREBY CERTIFY, That I attended deceased from

3/24

1922, to

4/2

1922,

that I last saw him alive on

4/2

1922,

and that death occurred, on the date stated above, at

2:40 p.m.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis.  
Renal Phosphoria.

Indefinite

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Clinical findings  
J. B. Jones, M. D.

4/2, 1922 Address

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

April 4 1922

20 UNDERTAKER

W. W. Shivers

ADDRESS

1018 Edmondson Ave

D 63110

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63110

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Municipal Hosp.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 60

ST.: 4

WARD)

2-FULL NAME

Johnnie Clark

(a) RESIDENCE NO.

609 N. Calverly St.

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

2.3 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Aminie N. Clark

6 DATE OF BIRTH (month, day, and year)

1849

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

73

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Walekman

(b) General nature of industry, business, or establishment in which employed (or employer)

obv

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Unknown

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Harp Reed

15

1922

Robert P. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-2-1922

17

I HEREBY CERTIFY, That I attended deceased from

4-1-1922, to 4-2-1922

that I last saw him alive on 4-2-1922

and that death occurred, on the date stated above, at 8:55 A.M.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis  
Chronic Nephritis

(duration) 10-15 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Arteriosclerosis

(duration) 20 yrs. mos. ds.

18 Where was disease contracted (if not at place of death?)

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Clyde McNeil

M. D.

43 10 40 (Address) Municipal Hosp. Bay View

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Cemetery

April 4 1922

20 UNDERTAKER

H. M. Routson

ADDRESS

2238 W. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63111

D 63111

## CERTIFICATE OF DEATH

1. PLACE OF DEATH

Bayview Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST., 17 WARD)

2. FULL NAME

Alice Patterson

(a) RESIDENCE NO.

1303 Regyle Ave.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1888

7 AGE

34

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Do.

12 MAIDEN NAME OF MOTHER

Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Bayview Hospital

15

Filed

19

Registrar

3-1922

Burial Permit 01022

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 2, 1922

17 I HEREBY CERTIFY, that I attended deceased from

Nov. 16, 1921, to April 2, 1922

that I last saw her alive on April 2, 1922

and that death occurred, on the date stated above, at 3:10 P. m.

The CAUSE OF DEATH\* was as follows:

Hernia (intestine protruding)

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Centro Spinal Les

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) H. J. Sedgwick, M. D.

4/3/1922 (Address) Bayview Hospital

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MAYAL

Apr 4, 1922

20 UNDERTAKER

ADDRESS 631

J. H. Holland

Herman Bell



D 63112

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63112

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *507 Wilson* ST. *14* WARD)

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Maggie Mickens*(a) RESIDENCE. No. *507 Wilson* ST. .... WARD. ....

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*Col*

5 Single, Married, Widowed,

or Divorced (write the word)

*Single*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Jan 1 - 1878*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*44**3**1*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Domestic*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)*— 070*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Va*

10 NAME OF FATHER

*Robert Harrison*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Va*

12 MAIDEN NAME OF MOTHER

*Isabelle Patterson*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*Va.*

14

Informant  
(Address)*Dr. Parker E. Hammond  
507 Wilson St*

15

Date

*Robert P. Harrison*

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*April 2 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar 24 1922 to Apr 2 1922*that I last saw her alive on *Apr 1 1922*and that death occurred, on the date stated above, at *1045 A. M.*

The CAUSE OF DEATH\* was as follows:

*Acute Cardiac Dilatation*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)*Broncho-Pneumonia*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

*Physical Examination*

(Signed)

*James Brown* M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Grovet Va*

20 UNDERTAKER

*Dr. H. Holland*

DATE OF BURIAL

*Apr 4 1922*

ADDRESS

*1631*

D 63113

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63113

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1115 Humbert St* ST. *24* WARD)2-FULL NAME *Patrick Clarke*(a) RESIDENCE NO. *1115 Humbert St* ST. \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *40* yrs. mos. ds.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*white married*

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of *Catherine*6 DATE OF BIRTH (month, day, and year) *1872*

7 AGE

Years

Months

Days

At LESS than 1 day, hrs. or min.

*50*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *laborer*(b) General nature of industry, business, or establishment in which employed (or employer) *Sugar Refining*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Ireland*10 NAME OF FATHER *John Clarke*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ireland*12 MAIDEN NAME OF MOTHER *Ellen Higgins*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*

14

Informant *Catherine Clarke*(Address) *1115 Humbert St*

15

*Robert F. Harrison,*

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/1/22* 19

17

I HEREBY CERTIFY, That I attended deceased from

*3/18*, 19*22*, to *4/1/22*, 19that I last saw him alive on *4/1/22*, 19and that death occurred, on the date stated above, at *9 am* m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis*  
*To my knowledge 13 days.*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

*Pulmonary edema*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no*

Date of

Was there an autopsy? *no*What test confirmed diagnosis? *examination*(Signed) *Jas H. O'Donnell*

M. D.

4/1, 1922

(Address) *1022 West St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Catholic Cem**April 1, 22*

20 UNDERTAKER

ADDRESS

*Margaret G. Flynn**1422 Right St*

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63114

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63114

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1729 Ruxton Ave. ST., 15 WARD)

## 2. FULL NAME

(a) RESIDENCE NO. 1729 Ruxton Ave. ST., 15 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed or divorced HUSBAND of (or) WIFE of Dora Barr6 DATE OF BIRTH (month, day, and year) 2/21/18847 AGE Years 68 Months 1 Days 12 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland10 NAME OF FATHER Not Known11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known12 MAIDEN NAME OF MOTHER Not Known13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

## PARENTS

14 Informant a Barr (Address) 1729 Ruxton Ave.

## 15

Robert P. Harrison

Filed

19

Burial Permit Clerk

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 192217 I HEREBY CERTIFY, That I attended deceased from March 27, 1922, to April 2, 1922, that I last saw him alive on April 2, 1922,and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical Examination(Signed) W. B. Simpson, M. D., 19 (Address) 2224 W. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Heaven Burial Home April 4<sup>th</sup> 1922

20 UNDERTAKER

ADDRESS

Carroll & Sons 1130 N. Gay St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

3-1922

D 63115

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 63115

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No.

Mercy Hospital

ST.

3

WARD)

## 2-FULL NAME

Josephina Cocuzzi

(Residence in Baltimore: No.

404 S High

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

F

4-COLOR OR RACE,

W

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)  
Widower

6-DATE OF BIRTH,

May

30

1847

(Month)

(Day)

(Year)

7-AGE,

74

yrs.

11

mos.

1

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House keeping

9-BIRTHPLACE,  
(State or Country),

Italy

10-NAME OF FATHER,

Nicholas Zampina

11-BIRTHPLACE OF FATHER  
(State or Country),

Italy

12-MAIDEN NAME OF MOTHER

Wilhelmina Zampina

13-BIRTHPLACE OF MOTHER  
(State or Country),

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

M. Gardina

(Address)

404 S High St

15-

Robert P. Harris

1922 Burial Permit Clerk

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr. 1, 1922

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an...  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said...  
I have not died...  
...that said deceased came to...  
topsy or inquiry...  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

Fract. skull  
Struck by wagon  
driven by...  
(Duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. J. P. M. D.

Apr. 2, 1922 (Address) 1039 Broadway

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL

New South Street

DATE OF BURIAL,

20-UNDERTAKER

Wendell Dyppel

ADDRESS

378 Ann



D 63116

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63116

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S.V. HOSP.#56, Ft. McHenry, Md.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Ft. McHenry, Md. ST. 24 WARD)

2-FULL NAME FLOYD E. GENTRY

(a) RESIDENCE NO. U.S.V. HOSP.#56, Ft. McHenry, Md. WARD 36

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 28 -- -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 886

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer

9 BIRTHPLACE (city or town) Kentucky (State or country)

10 NAME OF FATHER D.R. Gentry

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant EDGAR T. ROSENBROCK, Registrar (Address) U.S.V. HOSP.#56, Ft. McHenry, Md.

15 Filled Robert F. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2, 19 22

17 I HEREBY CERTIFY, That I attended deceased from Mar. 8, 1922, to April 2, 19 22.

that I last saw him alive on April 2, 1922.

and that death occurred, on the date stated above, at 2.45 p.m.

The CAUSE OF DEATH\* was as follows:

Sarcoma of abdomen

--- (duration) --- yrs. --- mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Clinical record report

(Signed) H. H. H. M. D.

4/2/22 SURGEON(R) 19 (Address) U.S.V. Hosp.#56, Ft. McHenry, Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Broadhead Ky. 4/3, 1922

20 UNDERTAKER

S. Hinson &amp; Co. E. Balto. Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

3-1922

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Stomach & intestines  
involved. Origin  
unknown*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63117

## CERTIFICATE OF DEATH.

D 63117

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 E. Winston St. WARD 27)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## WARD

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant  
(Address)

## 15

Filed

Robert P. Harrison,

19

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

## 17

I HEREBY CERTIFY, That I attended deceased from

Oct 1, 1921, to April 2, 1922.

that I last saw him alive on April 1, 1922.

and that death occurred, on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH\* was as follows:

Exhaustion of Liver

CONTRIBUTORY  
(Secondary)

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1922 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

## 20 UNDERTAKER

## DATE OF BURIAL

## ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63118

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63118

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 N. East Ave. ST., 76 WARD)

2-FULL NAME

(a) RESIDENCE NO. 113 N. East Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. C. Ritzel

6 DATE OF BIRTH (month, day, and year) Jan 1878

7 AGE 44 Years 3 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER John Frawley

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Ellen Hayes

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Mrs. Layman (Address) 42 N. East Ave.

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22, 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 1, 1922, to Apr 3, 1922,

that I last saw him alive on Apr 2, 1922, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH\* was as follows:

Wrenia

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Lobar Pneumonia

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) B. O. Kelly, M. D.

, 19 (Address) 100 N. Hanover Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

M. J. Carmel & Son 44 1922

20 UNDERTAKER L. A. Moran ADDRESS 3000 E. Baltimore



D 63119

## HEALTH DEPARTMENT—CITY OF BALTIMORE D 63119

## CERTIFICATE OF DEATH.

REGISTERED NO. 90

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO. 31 S. Stricker ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct. 12, 1876

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45

5

20

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

Obt.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

New York

10 NAME OF FATHER

Frank J. Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country)

New York

12 MAIDEN NAME OF MOTHER

Mary Merritt

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

New York

14

Informant (Address)

Mercy Hospital Record

15

Filed

ROBERT F. HARTMAN, 19

Burial Permit Clerk

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 2 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 18 1922, to Apr 2 1922,

that I last saw him alive on Apr 2 1922,

and that death occurred, on the date stated above, at 3:05 P.M.

The CAUSE OF DEATH\* was as follows:

Aortic Insufficiency and Cardiac decompensation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death?

no

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Marlboro, Ulster Co., N.Y. April 5 1922

20 UNDERTAKER

ADDRESS

Harry H. Witzke 1531 N. Lombard St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63120

## CERTIFICATE OF DEATH.

114 D 63120

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 Penn ST. 22 WARD)

## 2. FULL NAME Ethel Burley

(a) RESIDENCE No. 407 Penn ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Cal 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 24 1920

7 AGE 2 Years Months Days If LESS than 1 day, hrs. or min. 7 7

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. City

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Fannie Burley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) B. M. D.

14 Informant Fannie Burley (Address) 407 Penn St

15 Filed Robert F. Harrison, Registrar

Burial Permit Clerk.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-1-22

17 I HEREBY CERTIFY, That I attended deceased from 3-27-22, to 3-31-22, 19

that I last saw her alive on " 19

and that death occurred, on the date stated above, 11 AM 4-1-22

The CAUSE OF DEATH\* was as follows:

Acute Gastritis

CONTRIBUTORY (Secondary) Malnutrition, (duration) yrs. mos. 6 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. H. Caudy, M. D.

, 19 (Address) 1524 Hill Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Mt Auburn Cem April 1922

20 UNDERTAKER A. Jones

ADDRESS 207 S. Strider

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

1-1922



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63122

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1823 Eutaw Place ST.: 14 WARD)

2-FULL NAME Annie Crawford Hallidge

(a) RESIDENCE. No. 1823 Eutaw Place ST. WARD.  
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 5 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female white widowed

5a If married, widowed, or divorced

HUSBAND (or) WIFE of J. S. Hallidge

6 DATE OF BIRTH (month, day, and year) Oct 17, 1852

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
69 4 16

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Calvert County, Maryland

10 NAME OF FATHER James S. Crawford

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Pierson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant George H. Grom  
(Address) 1007 Cathedral St.

15 Filed APR 4 - 1922 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1922

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1922, to April 3, 1922, that I last saw him alive on April 3, 1922, and that death occurred, on the date stated above, at 3 30 P. M.  
The CAUSE OF DEATH\* was as follows:

Cardio-Renal Disease

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

Pulmonary Disease

(duration) — yrs. — mos. 2 ds.

15 Where was disease contracted If not at place of death? Washington D.C.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinician's Report

(Signed) George H. Grom, M. D.

, 19 (Address) 1007 Cathedral St. Baltimore, Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Washington D.C. Apr 4 1922

20 UNDERTAKER ADDRESS

John O. Mitchell 1201 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



D 63123

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

31 D 63123

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 930 Morris ST. 11 WARD)

## 2. FULL NAME

Mollie Moore

## (a) RESIDENCE NO.

930 Morris

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of A. L. Moore WIFE of6 DATE OF BIRTH (month, day, and year) 18957 AGE 27 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

W. Va.

## 10 NAME OF FATHER

Jenkins

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

W. Va.

## 12 MAIDEN NAME OF MOTHER

Caroline

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

W. Va.

## 14

Informant (Address)

A. L. Moore  
930 Morris St.

## 15

APR 4 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 1 192217 I HEREBY CERTIFY, That I attended deceased from Mar. 18th, 1922, to April 1st, 1922, that I last saw him alive on April 1st, and that death occurred, on the date stated above, at 4:55 p.m.

The CAUSE OF DEATH\* was as follows;

Tuberculosis of the bowels - (Chronic) - (duration) yrs. mos. ds.CONTRIBUTORY (Secondary) Partially Tuberculosis of the lungs (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Microscopic  
(Signed) Dr. R. Lee Ellis, M. D.  
1922 (Address) 924 Morris St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

Int. Auburn CemeteryApr 4, 22

## 20 UNDERTAKER

J. Brown Hall

## ADDRESS

1741 D. Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63124 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 E. 41<sup>st</sup>)ST. 7<sup>th</sup> WARD)

## 2-FULL NAME

Francis X. Reilly

(a) RESIDENCE. NO. 809 E. 41<sup>st</sup>ST. 28<sup>th</sup> WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 4<sup>th</sup> 1919

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

2 4 28

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

10 NAME OF FATHER Martin J. Reilly

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary P. Kehoe

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)

14 Informant Martin J. Reilly

(Address) 809 E. 41<sup>st</sup>

15 APR 4 - 1922 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3<sup>rd</sup> 1922

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1922, to April 3, 1922, that I last saw him alive on April 3, 1922,

and that death occurred, on the date stated above, at 9<sup>55</sup> a. m.

The CAUSE OF DEATH\* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Laryngeal respiration.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know.

Did an operation precede death? Date of April 2, '22.

Was there an autopsy? No.

What test confirmed diagnosis? No.

(Signed) Hugh Forsythe, M. D.

19 (Address) 424 E. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral Cemetery Apr. 4<sup>th</sup> 1922

20 UNDERTAKER ADDRESS

Lilly &amp; Zeller 400 N. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63125 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

113 D 63125

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3210 E. Balto. ST. 26 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emil Lawrence Cornell

(a) RESIDENCE. No. 3210 E. Balto. ST. 26 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 8 - 1921

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
4 22

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

10 NAME OF FATHER Emil Cornell

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Hazel Bafford

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)

14 Informant Emil Cornell, Father (Address) 3210 E. Balto. St.

15 Filed APR 4 - 1922 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1<sup>st</sup> 192217 I HEREBY CERTIFY, That I attended deceased from March 26, 1922, to April 1<sup>st</sup>, 1922, that I last saw him live on April 1<sup>st</sup>, 1922, and that death occurred, on the date stated above, at 4<sup>50</sup> P. M.

The CAUSE OF DEATH\* was as follows:

Gastro Enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed: Nataniel S. Mays, M.D. (Address) 3115 E. Baltimore

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cold Lawn Cemetery April 4 1922

20 UNDERTAKER

Lilly &amp; Zeiler 4038 Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63126

63126

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1054 William St.

ST. 24 WARD 101

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Noll

(a) RESIDENCE. No. 1054 William St.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 10 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Theresa Noll

6 DATE OF BIRTH (month, day, and year) May 19 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	10	13	

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Swift &amp; Co.

9 BIRTHPLACE (city or town). Balto. Md.  
(State or country)

10 NAME OF FATHER Jacob Noll

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.  
(State or country)

12 MAIDEN NAME OF MOTHER Minnie Pletz

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.  
(State or country)14 Informant Mrs. Theresa Noll  
(Address) 1054 William St.

15 APR 4 - 1922 ROBERT R. KRAUTER, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 30 1922 to April 2 1922 that I last saw him alive on April 2 1922 and that death occurred, on the date stated above, at 9-30 m.

The CAUSE OF DEATH\* was as follows:

Labor Pneumonia

(duration) yrs. mos. 4 ds.  
CONTRIBUTORY Exhaustion  
(Secondary) (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically  
(Signed) R. R. Campbell, M. D.  
April 22 1922 (Address) 1644 Hanover St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Olivet Cemetery

DATE OF BURIAL

4/5 1922

20 UNDERTAKER

J. Faw McCallly

ADDRESS

130 E Fort

RECORD OF DEATHS IN PRINT TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. Exact statement of occurrence is very important. See instructions on back of certificates.



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63127

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63127

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1528 Ashland Ave. 10 WARD)

2. FULL NAME

David Goldberg

(a) RESIDENCE NO.

1528 Ashland Ave.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 22 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Goldberg

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE Years 70 Months — Days — If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clothing

(b) General nature of industry, business, or establishment in which employed (or employer) Presser

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Jack Goldberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prussia

12 MAIDEN NAME OF MOTHER Rosa Goldberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prussia

14

Informant (Address)

Jack Lewis  
1439 E. Baltimore St.

15

APR 4 - 1922 ROBERT R. KRAUTER,  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3 1922

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1922, to April 3, 1922, that I last saw him alive on April 3, 1922, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH\* was as follows:

Broncho pneumonia  
(Preceded by chronic nephritis)  
(duration) 7 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Benj. Rushen, M. D.

Apr 3, 1922 (Address) 1804 Rutland St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenview Burial

4/4 1922

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 63128

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63128

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *on street 100 Blich / Maryland*)

2-FULL NAME

(Residence in Baltimore No. *415 N. Maderia*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH, *July 10, 1874* (Month) (Day) (Year)

7-AGE, *47* yrs., *9* mos., *22* ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Carpenter* (b) General nature of industry, business, or establishment in which employed (or employer) *D.S.*

9-BIRTHPLACE, (State or Country), *Baltimore*

10-NAME OF FATHER, *Wm A. Lynch*

11-BIRTHPLACE OF FATHER, (State or Country), *Pa.*

12-MAIDEN NAME OF MOTHER, *Laura Holland*

13-BIRTHPLACE OF MOTHER, (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary E. Lynch* (Address) *415 N. Maderia*

15- *APR 4 - 1922* 101. *ROBERT R. KRAUTER,* Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 1, 1913* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Apoplexy* (Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) (Duration) .... yrs. .... mos. .... ds.

(Signed) *R. R. Krauter* M. D. (Coroner) *R. R. Krauter* 415 N. Maderia (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, *Baltimore* DATE OF BURIAL, *April 5, 1922*

20-UNDERTAKER, *Girkler & Girkler* ADDRESS *1739 Eager*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63129

## CERTIFICATE OF DEATH.

REGISTERED NO.

D 63129

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *562 Mosher st* ST. *14* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Edna Viola Thomas*(a) RESIDENCE. NO. *562 Mosher st* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Columbian* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Mar, 31 1903*7 AGE Years *19* Months Days *1* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balt city* (State or country)10 NAME OF FATHER *Chas Thomas*11 BIRTHPLACE OF FATHER (city or town) *Balt city* (State or country)12 MAIDEN NAME OF MOTHER *Blanche Thomas*13 BIRTHPLACE OF MOTHER (city or town) *Balt city* (State or country)14 Informant *Blanche Thomas* (Address) *562 Mosher st*15 *2261-7814* ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr, 1 1922*17 I HEREBY CERTIFY, That I attended deceased from *March 26, 1922* to *April 1, 1922*, that I last saw her alive on *April 1, 1922*and that death occurred, on the date stated above, at *1740 P m.*

The CAUSE OF DEATH\* was as follows:

*Purpural Septicemia + Peritonitis*CONTRIBUTORY *Child birth* (duration) yrs. mos. *12* ds.(Secondary) (duration) yrs. mos. *12* ds.18 Where was disease contracted if not at place of death? *her home*Did an operation precede death? *N* Date ofWas there an autopsy? *N*What test confirmed diagnosis? *chumol* (Signed) *H. H. Gough* M. D.4-2-1922 address) *117 W Saratoga St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Laurel Park* *Apr, 4 1922*20 UNDERTAKER ADDRESS *598**Samuel Beasley* *Mar 11*

CAUSE OF DEATH IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63130

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63130

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1422 M. Carrollough* ST. *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *James E. Hughes*(Residence in Baltimore: No. *1422 M. Carrollough* St.; *61* yrs., *7* mos., *24* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*4-COLOR OR RACE, *Colored*5-SINGLE, *Married*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)6-DATE OF BIRTH, *Aug 7, 1860*

(Month)

(Day)

(Year)

7-AGE, *61* yrs., *7* mos., *24* ds.If LESS than 1 day,  
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular  
kind of work, *Barber*  
(b) General nature of industry, busi-  
ness, or establishment in which  
employed (or employer), *004*9-BIRTHPLACE,  
(State or Country), *Dallas Tex*10-NAME OF  
FATHER, *Unknown*11-BIRTHPLACE  
OF FATHER  
(State or Country), *Unknown*12-MAIDEN NAME  
OF MOTHER, *Unknown*13-BIRTHPLACE  
OF MOTHER  
(State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Salustine Hughes*(Address) *1422 M. Carrollough St.*

15-

APR 4 - 1922

ROBERT R. KRAUTER

Filed

191

Burial Permit Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 1st, 1922*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Feb 3rd 1922* to *April 1st 1922*that I saw him alive on *March 30th 1922*and that death occurred, on the date stated above, at *12:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Pneumonia & Relapse in  
Tuberculosis*(Duration) *2* yrs., *2* mos., *24* ds.CONTRIBUTORY *Heart disease*  
(Secondary)(Duration) *1* yr., *1* mos., *1* ds.(Signed) *W. B. Smith* M. D.*April 3rd 1922* (Address) *617 N. Charles*\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,  
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL.18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRAN-  
SIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL *Apr 4th 1922*20-UNDERTAKER *James E. Hughes*ADDRESS *314 N. Charles*

important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 63131

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 708-Brume ST., 17 WARD)

## 2-FULL NAME

Rahit Inustal

## (a) RESIDENCE NO.

708-Brume

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced. (write the word)

Male Negro Married

## 5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Julia Inustal

## 6 DATE OF BIRTH (month, day, and year)

3/1/1881

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

41 years

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Day laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Not working

## 9 BIRTHPLACE (city or town) (State or country)

Essex Va.

## 10 NAME OF FATHER

Henry Inustal

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va.

## 12 MAIDEN NAME OF MOTHER

Ethel Bell

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va.

## 14

Informant (Address)

Julia Inustal 708-Brume St.

## 15

Filed

19

ROBERT R. KRAUTER, Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

3/31/1922

## 17

I HEREBY CERTIFY, That I attended deceased from

3/26/1922, to 3/31/1922, that I last saw him live on 3/30/1922, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia formerly an alcoholic (duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Heart trouble (duration) 5 yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Robert H. Jackson M.D. 708-Brume St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

NOVA 1922

## 20 UNDERTAKER

James H. Hensley

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63132

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63132

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2042 N Fulton Ave* ST. *15* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *William J. Lynch Jr*(a) RESIDENCE. NO. *2042 N Fulton Ave* ST. *15* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *7* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Virginia E. Lynch*6 DATE OF BIRTH (month, day, and year) *April 1, 1922*7 AGE Years *44* Months *-* Days *-* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Publisher*(b) General nature of industry, business, or establishment in which employed (or employer) *Racing Form*(c) Name of employer *Wm J. Lynch*9 BIRTHPLACE (city or town) (State or country) *N.Y. N.Y.*10 NAME OF FATHER *Wm J. Lynch Sr*11 BIRTHPLACE OF FATHER (city or town) (State or country) *N.Y. N.Y.*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *N.Y. N.Y.*14 Informant *Virginia E. Lynch* Address *2042 N Fulton Ave*

ROBERT R. KRAUTER,

Burial Permit Clerk.

APR 4 - 1922

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 3, 1922*17 I HEREBY CERTIFY, That I attended deceased from *April 1, 1922* to *April 3, 1922* that I last saw him alive on *April 1, 1922* and that death occurred, on the date stated above, at *6:00 a.m.*

The CAUSE OF DEATH\* was as follows:

*Angina Pectoris*CONTRIBUTORY (Secondary) *Acute Indigestion* (duration) yrs. mos. ds.(duration) yrs. mos. ds. *2* ds.18 Where was disease contracted? ☒ If not at place of death?Did an operation precede death? ☒ Date of ☒Was there an autopsy? ☒

What test confirmed diagnosis?

(Signed) *Wm J. Lynch* M. D.43712 (Address) *3400 Yarrow Ave*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Cathedral C.* *April 5, 1922*

20 UNDERTAKER ADDRESS

*Martin F. Hayes & Son* *1837 W North*CAUSE OF DEATH IN PAINTED TERMS, SO THAT IT MAY BE PROPERLY  
TION is very important. See instructions on back of certificates.

D 63133

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

APR 4 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 21, 1922, to April 3, 1922,

that I last saw him alive on April 2, 1922,

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63134

## CERTIFICATE OF DEATH.

D 63134

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 19 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Margaret Cornell

## (a) RESIDENCE NO.

106 S. Cary St.

## ST.

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 7 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

Single, Married, Widowed,  
or Divorced (circle one)Female WhiteWidowed5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofWilliam Louis Cornell

## 6 DATE OF BIRTH (month, day, and year)

Mar 18 - 1872

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.50.016

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of workHousework(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore Md

## 10 NAME OF FATHER

Walter Schimpf11 BIRTHPLACE OF FATHER (city or town)  
(State or country)Baltimore Md

## 12 MOTHER'S NAME OF MOTHER

Emily Kelley13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Baltimore Md

## 14

Informant  
(Address)JOHNS HOPKINS HOSPITAL

## 15

APR 4 - 1922ROBERT R. KRAUTER,Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 - 1922

17

I HEREBY CERTIFY, That I attended deceased from  
April 3 - 1922 to April 3 - 1922,  
that I last saw her alive on April 3 - 1922,  
and that death occurred, on the date stated above, at 4:10 m.

The CAUSE OF DEATH\* was as follows:

Chronic nephritis(duration) 3 yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Urinalysis -

(Signed)

, 19 (Address)

J. H. H.\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

MOVING

London ParkApr 7 2 1922

## 20 UNDERTAKER

Mr. Weber, 2503

## ADDRESS

Baltimore

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

63135

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 N. Mount Street ST., 19 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME Jerry Larence Lewis

(a) RESIDENCE NO. 519 N. Mount Street.

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 7 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Negro 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of Fanny Lewis (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 11th. 1872

7 AGE Years 50 Months 0 Days 20 If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hod carrier

(b) General nature of industry, business, or establishment in which employed (or employer) Construction of buildings

(c) Name of employer Primer Co.

## 9 BIRTHPLACE (city or town) (State or country)

Essex Co. Va

10 NAME OF FATHER George Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Essex Co. Va.

12 MAIDEN NAME OF MOTHER Adline Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Essex Co. Va.

14 Informant Fannie Lewis (Wife) (Address) 519 N. Mount St.

15 APR 4 1922 ROBERT R. KRAUTER Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/31/22 19

17 I HEREBY CERTIFY, That I attended deceased from March 2nd., 1922, to March 31 1922.

that I last saw him alive on March 31st 1922.

and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH\* was as follows:

Chronic Encephalitis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY Traumatism of the brain received (Secondary) by a blow on head (duration) 27 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam

(Signed) Walter C. Jackson M. D.

19 (Address) 1618 W. Mulberry St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL DATE OF BURIAL

20 UNDERTAKER

ADDRESS 378

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

Patient has been an invalid since receiving injuries when he fell three stories while carrying a load.

*Accidental fall off Scaffold*

*Levinis*  
vs

*H. Pymer et al*

The Baltimore City Court

*DL 3135*

*Sept.* Term, 192 *2*

Mr. *B. Hampson Jones* *Health Com.*

You are hereby summoned to attend this Court, on *Monday* the *20* day of *Nov.* 192 *2*, at ~~10 o'clock A.M.~~ to testify for *Plaintiffs*

in the above named case, and to attend said Court daily until duly discharged.

By order of the Court, *immediately*

THOMAS F. McNULTY, Sheriff of Baltimore City

more, *11-20-* 192 *2*

(Bring this summons with you.)

~~Be~~ Be punctual in attendance or you will be attached.

ROOM 134, COURT HOUSE

Deputy No. *3*

FANNIE LEWIS

VS.

J. H. PYMER AND  
EMPLOYERS' LIABILITY  
ASSURANCE CORPORATION.

IN THE

BALTIMORE CITY COURT

Mr. Clerk:

Kindly issue summons for the following named witness to testify for the plaintiff, and make the same returnable immediately:

C. Hampson Jones, Health Commissioner, Health Department, City. Subpoena duces tecum to bring into Court the records showing the cause of death of Jerry Lewis, who died on Marcy 31, 1922.

\_\_\_\_\_  
Attorney for Plaintiff.



FANNIE LEWIS

:

IN THE

VS.

:

J. H. FYMER AND  
EMPLOYERS' LIABILITY  
ASSURANCE CORPORATION.

:

BALTIMORE CITY COURT.  
Room 226.  
Case No. 6.

:

---

Mr. Clerk:

Kindly issue summons for the following named witnesses to testify for the plaintiff, and make the same returnable to Friday, January 12, 1923, at 10 A.M.:

C. Hampson Jones, Health Commissioner, Health Department, City. Subpoena duces tecum to bring into Court the records showing the cause of death of Jerry Lewis, who died on March 31, 1922.

---

Attorney for Plaintiff.

Lewis

vs.

Pymetol

Court of Judge at Large, No. 3

Mr. C. Hampton Jones

Jan Health Sept Friday

Term, 192

3

You are hereby summoned to attend this Court,

on

15

day of

January

192

3

, at 10 o'clock A. M., to testify for

Plaintiff

in the above named case, and to attend said Court

daily until duly discharged. (Bring this summons with you.) By order of the Court.

THOMAS F. McNULTY, Sheriff of Baltimore City

Baltimore,

Jan 11

192

3

Be punctual in attendance or you will be attached.

Deputy No.

3

ROOM 226, COURT HOUSE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63136

## CERTIFICATE OF DEATH.

D 63136  
PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *1818 Barkley* ST. *12* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Julia Fenge*

(Residence in Baltimore: No. *1818 Barkley* St. *50* yrs., *50* mos., *50* ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

SEX, *Female*

4-COLOR OR RACE, *White*

5-SINGLE, *Married*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH, *July 11, 1852*

(Month) (Day) (Year)

7-AGE, *69* yrs., *8* mos., *21* ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *none*  
(b) General nature of industry, business, or establishment in which employed (or employer) *131*

9-BIRTHPLACE, (State or Country), *Harford Co. Md.*

10-NAME OF FATHER, *Chas P. Burns*

11-BIRTHPLACE OF FATHER (State or Country), *Washington D.C.*

12-MAIDEN NAME OF MOTHER, *Elizabeth Woods*

13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. H. Fenge*

(Address) *1818 Barkley*

15-APR 4 - 1922

Filed... 191... ROBERT R. KRAUTER, Registrar.

Death Permit

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 2, 1922*

(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry

found that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:  
*Heart disease*

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *J. H. Fenge* M. D. (Coroner)

(Address) *7132 R. Road*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, *London Park*

DATE OF BURIAL, *4/4/22*

UNDERTAKER, *Henry W. Mears & Son*

ADDRESS, *805 N. 6 St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63137

## CERTIFICATE OF DEATH.

D 63137

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1545 N. Fulton Ave

ST., 15 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Almira Marie Lemmon

(a) RESIDENCE NO. 1545 N. Fulton Ave

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed.

5a If married, widowed, or divorced HUSBAND of Reuben Robert Lemmon (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 21st, 1890

7 AGE Years 31 Months 7 Days 12 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Md Casualty Co.

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Wm. H. Driscoll

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Birmingham

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Mrs Elizabeth Driscoll (Address) 1545 N. Fulton Ave.

15 APR 4 - 1922 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3rd, 1922

17 I HEREBY CERTIFY, That I attended deceased from March 22nd, 1922, to April 2nd, 1922, that I last saw him alive on April 2nd, 1922, and that death occurred, on the date stated above, at 3:45 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Acute myocarditis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. Driscoll, M. D.

444 1922 (Address) 17014 Fulton Avenue

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Manner and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Baltimore Cemetery

DATE OF BURIAL

April 6-1922

20 UNDERTAKER

Bertram W. P. E.

ADDRESS

15337 N. Fulton Ave.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63138

## CERTIFICATE OF DEATH.

31 D 63138

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2310 Elsinor Ave

ST., 15 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Bond Woolf

(a) RESIDENCE NO. 2310 Elsinor Ave

ST., WARD

(Usual place of abode)  
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, write the word Married

5a If married, widowed, or divorced  
(or) WIFE of Rev Ernest L. Woolf.

6 DATE OF BIRTH (month, day, and year) June 23rd 1873

7 AGE Years 48 Months 9 Days 10 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER J. Bosley Bond

11 BIRTHPLACE OF FATHER (city or town) Harford Co. Maryland. (State or country)

12 MAIDEN NAME OF MOTHER Sarah Carson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Rev E. L. Woolf (Address) 2310 Elsinor Ave.

15 APR 4 - 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3rd 1922

17 I HEREBY CERTIFY That I attended deceased from

Mar. 11 - 1922 to Apr. 3 - 1922

that I last saw her alive on March 31 - 1922

and that death occurred, on the date stated above, at 6:30 A. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary &amp; laryngeal tuberculosis.

Active (duration) about one year.

CONSTITUTIONARY began about 5 or 6 yrs. ago.

(Secondary) Latent (duration) about 4 yrs.

18 Where was disease contracted (P) if not at place of death?

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? See your records.

(Signed) O. St. Hoffman M. D.

4/4, 1922 Address 3402 Walbrook Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cemetery

DATE OF BURIAL April 5, 1922

UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



D 63140

Spec. 6-9-19 H. P. Co. 1000 Bks.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

✓ D 63140

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *68 Darby St.* ST. *9* WARD)

## 2-FULL NAME

(a) RESIDENCE, NO. *68 Darby St.* ST. *9* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *45* yrs. — mos. — ds. How long in U. S., if of foreign birth? *45* yrs. — mos. — ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, *Single* *Married* (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *June 25/1876*7 AGE Years *45* Months *9* Days *9* If LESS than day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balts city, Maryland.* (State or country)10 NAME OF FATHER *William Hood.*11 BIRTHPLACE OF FATHER (city or town) *Maryland.* (State or country)12 MAIDEN NAME OF MOTHER *Alexina Hussup.*13 BIRTHPLACE OF MOTHER (city or town) *Maryland.* (State or country)14 Informant *Alexina Hood.* (Address) *68 Darby St.*

15

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 3, 1922*17 I HEREBY CERTIFY, That I attended deceased from *May 1st, 1919*, to *April 3rd, 1922*, that I last saw her alive on *April 2nd, 1922*, and that death occurred, on the date stated above, at *9:50 A.M.* The CAUSE OF DEATH\* was as follows:*Cerebral meningitis & brain abscess.*(duration) *2* yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) *2* yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *May 1919*Was there an autopsy? *No*What test confirmed diagnosis? *Microscopic findings*(Signed) *B. G. Davis*, M. D.19 Address *14 N. Main St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*St. Marys Hospital* *4/5* 192220 UNDERTAKER *Walter Davis* ADDRESS *3307*

TION is very important. See instructions on back of certificates.

D 63141

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63141

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *2101 E Federal* ST., *8* WARD)

## 2. FULL NAME

*Johanna Schraml*

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *2101 E. Federal* ST., *8* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S., if of foreign birth? *35* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*Jacob Schraml*6 DATE OF BIRTH (month, day, and year) *Sept 23 1866*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *56*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Austria*

10 NAME OF FATHER

*Joseph Taubert*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Austria*

12 MAIDEN NAME OF MOTHER

*Rose Heintzel*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)*Jacob Schraml*  
*2101 E. Federal St.*

15

APR 4 - 1922

*LLY*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 2 1922*17 I HEREBY CERTIFY, that I attended deceased from *Apr 15*, 19*22* to *Apr 2*, 19*22*, that I last saw him alive on *April 2*, 19*22*, and that death occurred, on the date stated above, at *7 P* m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Stomach*CONTRIBUTORY  
(Secondary)*Cardiac Asthma*  
(duration) yrs. *15* ds. *2* mos.18 Where was disease contracted if not at place of death? *at Place of death*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

*Physician diagnosis X Ray*

(Signed)

*J. B. Fulsom* M. D.  
*1901 E. Federal St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Redeemer Cem* *April 4 1922*

20 UNDERTAKER

ADDRESS

*Frank A. Finch* *915 E. Gay*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



D 63142

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63142

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1000 W. Lexington ST.: 18 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Charles N. Eisenman

## (a) RESIDENCE. No.

1000 W. Lexington ST.,

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

39 yrs. 2 mos. 21 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

white

## 5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Jan. 12, 1883

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

39

2

21

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Nuckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

## 10 NAME OF FATHER

John S. Eisenman

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

## 12 MAIDEN NAME OF MOTHER

Mary Kuhl

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

## 14

Informant (Address)

Mamie Steinkraus  
709 S. Lakewood Ave

## 15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 3 1922

I HEREBY CERTIFY that I attended deceased from

April 3/22 1922

that I last saw him alive on April 3/22 1922

and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH\* was as follows:

Cerebral Thrombosis

Duration (duration) yrs. mos. ds.

4/2/22 1922

Secondary (duration) yrs. mos. ds.

Duration (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. C. Stant, M. D.

4/2/22 1922

Address 1922

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REINTERMENT

DATE OF BURIAL

ADDRESS 1922

Nancy W. Ehlert w. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1922

D 63143

HEALTH DEPARTMENT—CITY OF BALTIMORE

63143

## CERTIFICATE OF DEATH

1. PLACE OF DEATH

Morrow Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1122 N. Mount ST. 16 WARD)

2. FULL NAME

Clarence Williams

(a) RESIDENCE NO.

Cobles Creek, Matthews Co. Va.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male Black Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

November 1902

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

19 — —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Fireman on ship

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Va.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Unknown

14

Informant  
(Address)Morrow Hospital  
1122 N. Mount St.

15

Filed

Robert E. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-1-1922

17

I HEREBY CERTIFY, That I attended deceased from

3-11-1922, to 4-1-1922.

that I last saw him alive on 4-1-1922

and that death occurred, on the date stated above, at 9:45 p.m.

The CAUSE OF DEATH\* was as follows:

Broncho-pneumonia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY  
(Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Howard S. Tolson, M. D.

4/3, 1922

(Address) 1122 N. Mount St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Cricket Hill, Va.

4/4 1922

20 UNDERTAKER

ADDRESS 1127

S. Linsom &amp; Bro E. Baltest

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

4-1922

Burial Permit Clerk.

D 63144 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63144

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1522 Battery Ave ST. 24 WARD) 129

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Kate Lown

(a) RESIDENCE. NO. 1522 Battery Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Jew 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1850. 9. 23

7 AGE 71 Years 6 Months 10 Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Md. (State or country)

10 NAME OF FATHER Jacob Bluemaur

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mrs Lown Son (Address) 1522 Battery Ave

15 1922 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4. 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1919, to 4. 3, 1922, that I last saw her alive on 4. 3, 1922, and that death occurred, on the date stated above, at 8:10 P. M. The CAUSE OF DEATH\* was as follows:

Myocarditis

CONTRIBUTORY (Secondary)

Chronic Bright's dis (duration) 3 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. J. Surlington, M. D.

4. 3. 1922 Address 102 E Fort Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Wood Lawn

April 6 1922

20 UNDERTAKER

William Cook

ADDRESS 502

E North Ave

CAUSE OF DEATH IN PRINTING. See instructions on back of certificates. TION is very important.

D 63145

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63145

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE (No. *1911 Frederick* ST. WARD)

## FULL NAME

(Residence in Baltimore, No. *1911 Frederick St*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos., ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE

*White*5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)*Married*

6-DATE OF BIRTH

*Aug 6, 1855*

(Month)

(Day)

(Year)

7-AGE

*66* yrs. *7* mos. *7* ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,  
(State or Country).

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER  
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

-1902

191

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

*April 3, 1902*

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest*  
(Inquest, au-topsy or inquiry.) find that said deceased came to death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Pat. Cur. Heart*  
(Duration)..... yrs..... mos..... ds.CONTRIBUTORY  
(Secondary)(Duration)..... yrs..... mos..... ds.  
(Signed)..... M. D.  
(Coroner.)  
*Apr 4, 1902* (Address).....

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

*Burgess Estate Belair Md* *Apr 6, 1902*

20-UNDERTAKER

ADDRESS

*William Beck 5026 North An*



D 63146

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63146

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 3 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Cox(a) RESIDENCE. NO. 817 E. Pratt St.ST. 3 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18567 AGE Years Months Days If LESS than 1 day, hrs. or min. 65 -- --

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland10 NAME OF FATHER Nicholas Cox11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland14 Informant (Address) Hospital Records, Municipal Hospital.

UNIVERSITY OF MARYLAND

20 UNDERTAKER

Brooklyn Health,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 192217 I HEREBY CERTIFY, That I attended deceased from March 31 1922 to April 1 1922, that I last saw him alive on April 1 1922, and that death occurred, on the date stated above, at 7:20 P.m.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency

(duration) yrs. / mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Clayton M. Neil M. D.4/3/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

APR 1 1922

ADDRESS

D 63147

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63147

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Boy View Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No.

ST. 38 WARD

2-FULL NAME

Charles Small

(a) RESIDENCE NO.

Unknown

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, Divorced, (write the word)

Male Black Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1898

7 AGE Years Months Days

34

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Unknown

10 NAME OF FATHER

Do

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Do.

12 MAIDEN NAME OF MOTHER

Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Do.

14 Informant (Address)

Boy View Hospital  
Baltimore, Md.

15

Filed

4-1922

Robert P. Hartman

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 1, 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1921, to April 1, 1922

that I last saw him alive on April 1, 1922 and that death occurred, on the date stated above, at 5:25 P. m.

The CAUSE OF DEATH\* was as follows:

General Paralysis (of the chronic)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death? Date of

No

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical &amp; Serological

(Signed)

N. J. Adams with

4/4/22 Address

Boy View Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

1922

Baltimore Health

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63148

## CERTIFICATE OF DEATH.

63148

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2020 Bunt ST., 14 WARD)

## 2. FULL NAME

Wilson Wesley

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

2020 Bunt

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Apr 17 1892

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

291113

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

## 10 NAME OF FATHER

Elyah Wesley

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

## 12 MAIDEN NAME OF MOTHER

Mary Miller

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

## 14

Informant (Address)

Elyah Wesley  
2020 Bunt St

## 15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Apr 4 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Apr 1, 1922, to Apr 4, 1922.that I last saw him alive on Apr 3, 1922.and that death occurred, on the date stated above, at 3:45 A. m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis of Lungs(duration) 5 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Sputum(Signed) William Frey, M. D.4/4, 1922 (Address) 1928 Pa Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

Mt Auburn Cem - 7 1922

## 20 UNDERTAKER

## ADDRESS

George H. Holland  
1631 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63149

## CERTIFICATE OF DEATH.

D 63149

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1131 Bolton St.* ST. *11* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Richard Wrin*(a) RESIDENCE. NO. *1131 Bolton St.* ST. *11* WARD. (Usual place of abode)Length of residence in city or town where death occurred *8* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *Cal* 5 Single, Married, Widowed, or Divorced (write the word) *single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Dec. 24-1895*7 AGE Years *26* Months *3* Days *9* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Porter at the gas*(b) General nature of industry, business, or establishment in which employed (or employer) *building*

(c) Name of employer

9 BIRTHPLACE (city or town) *Va.* (State or country)10 NAME OF FATHER *John Wrin*11 BIRTHPLACE OF FATHER (city or town) *Va.* (State or country)12 MAIDEN NAME OF MOTHER *Retta Russ*13 BIRTHPLACE OF MOTHER (city or town) *Va.* (State or country)14 Informant (Address) *Margaret Wrin 1131 Bolton St.*15 Filed *Robert P. Harrison* Registrar

-1922 Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH, (month, day, and year) *April 2 1922*17 I HEREBY CERTIFY, That I attended deceased from *Mar 28*, 1922, to *April 2*, 1922.that I last saw him alive on *April 2*, 1922.and that death occurred, on the date stated above, at *6 P.* m.

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*(duration) *—* yrs. *—* mos. *8* ds.

CONTRIBUTORY (Secondary)

(duration) *—* yrs. *—* mos. *—* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *H. H. Peltzman*, M. D., 19 (Address) *817 Hamilton Ter*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Laurel Cnty* *4-6-22*

20 UNDERTAKER ADDRESS

*George T. A. Gibson 573 Laurel St*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63150

## CERTIFICATE OF DEATH.

D 63150

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 S. Norris ST. 19 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Stricker(a) RESIDENCE. NO. 307 S. Norris ST. \_\_\_\_\_ WARD. \_\_\_\_\_

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 5 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H. Stricker6 DATE OF BIRTH (month, day, and year) Oct. 30, 18837 AGE Years 38 Months 5 Days 2 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md (State or country)10 NAME OF FATHER Samuel A. Semmonh11 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country)12 MAIDEN NAME OF MOTHER Martha E. Addison13 BIRTHPLACE OF MOTHER (city or town) Del. (State or country)14 Informant Charles H. Stricker (Address) 307 S. Norris St15 Filed Robert P. Harrison, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 2 192217 I HEREBY CERTIFY, That I attended deceased from Mar 27, 1922, to April 2, 1922, that I last saw him alive on April 1, 1922, and that death occurred, on the date stated above, at 7:10 A. M. The CAUSE OF DEATH\* was as follows:Chronic Interstitial Nephritis(duration) yrs. 1 mos. ds.CONTRIBUTORY (Secondary) Uremia(duration) yrs. mos. 3 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. S. McKieffer M. D.Address 2320 Washington Blvd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mr. Oliver Cem. Apr 5 1922

20 UNDERTAKER

Messrs J. M. Gumpel & Son 801 N. Fayette

TION is very important. See instructions on back of certificates.

A-1922 Burial Permit Clerk.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63151

## CERTIFICATE OF DEATH.

179 D 63151

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 409 E 31<sup>st</sup> St. 17<sup>th</sup> WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Albion H. Allison

## (a) RESIDENCE NO.

409 E 31<sup>st</sup>

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos.

ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M.

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar 16/1846

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

75

4

19

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Belt Co.

10 NAME OF FATHER

Joseph Allison

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa

12 MAIDEN NAME OF MOTHER

Maria Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Mrs Jackson 409 E 31<sup>st</sup> St.

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1922

17

I HEREBY CERTIFY, That I attended deceased from

April 1917, to April 2, 1922.

that I last saw him alive on April 1, 1922.

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. H. H. M. D.

4-3, 1922 (Address) 5600 York Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-NOVAL

DATE OF BURIAL

Proph. Cem. Grounds 4/5-1922

20 UNDERTAKER

ADDRESS

Wm. Cook

H. H. H. H. H.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

4-1922

D 63152

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63152

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. *3106 Bayly St.* ST. *12* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *3106 Bayly St.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., *50* mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country),10-NAME OF  
FATHER,11-BIRTHPLACE  
OF FATHER  
(State or Country),12-MAIDEN NAME  
OF MOTHER,13-BIRTHPLACE  
OF MOTHER  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

APR 5 - 1922

ROBERT K. KRAUTER,

Burial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

(Month)

(Day)

19*22*  
(Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry,

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Cholelithiasis  
of heart*  
(Duration)..... yrs..... mos..... ds.CONTRIBUTORY  
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.  
(Coroner)

(Address).....

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the  
of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D 63153

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63153

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 Hollins ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha V. Bynum

(a) RESIDENCE NO. 1504 Hollins ST. 19 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James L. Bynum

6 DATE OF BIRTH (month, day, and year) Jan 20, 1856

7 AGE Years 66 Months Days If LESS than 1 day, ....hra. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer) housewife

(c) Name of employer

9 BIRTHPLACE (city or town) Md. Balto. (State or country)

10 NAME OF FATHER Geo. M. Clay

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Martha M. King

13 BIRTHPLACE OF MOTHER (city or town) Pa. (State or country)

14 Informant Mary Alice Clay (Address) 1213 B. St. E.

15 APR 5 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 3 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to Apr 3, 1922, that I last saw her alive on Apr 3, 1922, and that death occurred, on the date stated above, at 1045 P.M. The CAUSE OF DEATH\* was as follows:

Angina Pectoris

(duration) 4 yrs. mos. ds.

CONTRIBUTORY Acute Indigestion (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar E. Travers, M. D.

, 19 (Address) 1520 Hollins St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Memorial Chapel Phone No 4. Apr 6 1922

20 UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 63154

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1032 Patapsco St. ST. 23 WARD)

REGISTERED NO. 63154  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Edna S. Anderson.

## (a) RESIDENCE NO.

1032 Patapsco St. ST. 23 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. 9 ds. How long in U. S., if of foreign birth? ———— ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female. 4 COLOR OR RACE White. 5 Single, Married, Widowed, or Divorced, (write the word) Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 25th. 1919

7 AGE Years Months Days If LESS than 1 day, hrs or min. 2 3 9

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER Charles Anderson.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Martinsburg, W. Va.

12 MAIDEN NAME OF MOTHER Mary E Runkles.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Martinsburg, W. Va.

14 Informant Charles Anderson. (father)

(Address)

1032 Patapsco St.

15

APR 5 - 1922

ROBERT R. KRAUTER  
Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3rd 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1922, to April 3rd, 1922.

that I last saw her alive on April 3rd, 1922.

and that death occurred, on the date stated above, at 10.50 p. m.

The CAUSE OF DEATH\* was as follows:

Cobar Pneumonia.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

Abnoea.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? ————

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis.

(Signature) Otto W. Reinhardt, M. D.

4/4, 1922 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Western Cemetery Apr 5 1922

C. D. BAKER

ADDRESS

John Q. Mitchell 1201 W. Fayette

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63155

## CERTIFICATE OF DEATH.

179 D 63155

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1034 Valley

ST. 10 WARD)

## 2-FULL NAME

Annie. G. Delany

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE NO.

1034 Valley

ST. 10 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced

(or) WIFE of

John. G. Delany

## 6 DATE OF BIRTH (month, day, and year)

Jun. 18, 1868

## 7 AGE

Years

Months

Days

II LESS than

I day, hrs.

or min.

54

2

15

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

## 10 NAME OF FATHER

Patrick Kelley

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

## 12 MAIDEN NAME OF MOTHER

Mary Cunningham

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

## 14

Informant (Address)

Mr. John. G. Delany 1034 Valley

## 15

Filed

APR 5 - 1922

ROBERT R. KRAUTER,

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 3, 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Jan 1, 1922, to April 3, 1922, that I last saw her alive on April 3, 1922

and that death occurred, on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic interstitial nephritis

(duration) 1 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

1034 Valley &amp;

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical

(Signed)

James M. Keelson

M. D.

(Address)

700 E. Charles

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral Cemetery

## DATE OF BURIAL

April 6, 1922

## 20 UNDERTAKER

Henry Horck Lee

## ADDRESS

1301 E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

154963156

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 D 63156

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 22 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

John Bares

## (a) RESIDENCE NO.

35 E York St. City

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Unknown

How long in U.S. if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Single

## 6 If married, widowed, or divorced

Married of Mrs. M. L. Lean (Friend), Same address.

## 6 DATE OF BIRTH (month, day, and year)

Dec. 5, 1882

## 7 AGE

39

Years

Months

3

Days

29

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Utd.

## 10 NAME OF FATHER

Henry Bares

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Caroline Launziger

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Utd.

## 14

Informant (Address)

JOHNS HOPKINS HOSPITAL, Records

## 15

Registrar

APR 5 - 1922ROBERT R. KRAUTER,Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 3, 1922

## 17

I HEREBY CERTIFY, That I attended deceased from April 1, 1922 to April 3, 1922, that I last saw him alive on April 3, 1922, and that death occurred, on the date stated above, at 6:40 A. M.

The CAUSE OF DEATH\* was as follows:

Chemia(duration) yrs. mos. ds. 12 ds.

## CONTRIBUTORY (Secondary)

Chronic nephritis not known.

## 18 Where was disease contracted

if not at place of death? NoneDid an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

Blood chemist(Signed) Dr. R. D. Denaide, M. D.Address Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

BaltimoreApril 5, 1922

## 20 UNDERTAKER

## ADDRESS

Joseph Ahrens221 Burg

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

D 63157

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63157

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 227 W. McComas St. St. 23 Ward)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

George R. Wicklain.

86 6 17  
St.; yrs. mos. ds.)

(Residence in Baltimore: No. 227 W. McComas St. St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male.

## 4-COLOR OR RACE.

White.

5-Single,  
Married,  
Widowed,  
or Divorced.  
(Write the word.)

Married.

## 6-DATE OF BIRTH

September 17th. 1855.

(Month)

(Day)

(Year)

## 7-AGE.

66 yrs. 6 mos. 17 ds.

## 8-LESS than 1 day.

hrs. or min.?

## 9-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Contractor.

(b) General nature of industry, business, or establishment in which employed (or employer).

vib

## 10-BIRTHPLACE.

(State or Country).

Baltimore, Md.

## 11-NAME OF FATHER.

Charles Wicklein.

## 12-BIRTHPLACE OF FATHER.

(State or Country).

Germany.

## 13-MAIDEN NAME OF MOTHER.

Anna Marie Schen.

## 14-BIRTHPLACE OF MOTHER.

(State or Country).

Germany.

## 15-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benjamin F. Wicklein. (son)

(Address) 227 W. McComas St.

## 16-

APR 5 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

April 3rd. 1922.

(Month)

(Day)

1922 (Year)

## 17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Angina Pectoris.

Obstruction of the Coronary Arteries.

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto M. Bonhardt M. D.

(Coroner)

April 4 1922 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

## Former or usual residence.

## 19-PLACE OF BURIAL OR REMOVAL.

## DATE OF BURIAL.

Mt. Olivet Cem

4/6 1922

## 20-UNDERTAKER.

## ADDRESS

L. Faw McCallly

130 E. Fort



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63158

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1205 E. Preston ST. 10 WARD)2-FULL NAME Berkey Kerman(a) RESIDENCE. NO. 1205 E. Preston ST., WARD.(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 31-227 AGE Years Months Days If LESS than 1 day, hrs. or min. 10 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bethesda Md. (State or country)10 NAME OF FATHER Bernard Kerman11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)12 MAIDEN NAME OF MOTHER Sadie Evans13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)14 Informant Mrs. Kerman (Address) 1205 E. Preston15 Filed APR 5 - 1922 ROBERT R. KEATINGE Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31 192217 I HEREBY CERTIFY, That I attended deceased from Mar 01, 1922, to Mar 31, 1922.that I last saw him alive on Mar 31, 1922.and that death occurred, on the date stated above, at S. 408 m.The CAUSE OF DEATH\* was as follows: Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. [Signature] M. D.4/4, 1922 Address 1 E. Randall St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Lorraine [Signature] 4/5 1922

20 UNDERTAKER ADDRESS

J. Hew M. Conly 130 E. Fort

TION is very important. See instructions on back of certificates.

63159

## HEALTH DEPARTMENT—CITY OF BALTIMORE

63159

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Union Memorial Hospital* 101-001  
 CITY OF BALTIMORE: (No. *1514* *Division St* ST.: *14* WARD) REGISTERED NO. *144*  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
 2-FULL NAME *Master Gilbert Simes Steiner*  
 (a) RESIDENCE. No. *1631* *Eutaw Place* ST., *14* WARD. *Resident*  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred *6* yrs. *10* mos. *22* ds. How long in U. S., if of foreign birth? *6* yrs. *10* mos. *22* ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*  
 5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Single*  
 6 DATE OF BIRTH (month, day, and year) *May 12 1915*  
 7 AGE Years *6* Months *10* Days *22* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *School-boy*  
 (b) General nature of industry, business, or establishment in which employed (or employer) *—*  
 (c) Name of employer *—*

## 9 BIRTHPLACE (city or town) (State or country)

*Baltimore*  
*Maryland*

## 10 NAME OF FATHER

*Bernard C Steiner*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Guilford*  
*Connecticut*

## 12 MAIDEN NAME OF MOTHER

*Ethel Milligan*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*New York City*  
*New York*

## 14

Informant *Bernard C Steiner (father)*  
 (Address) *1631 Eutaw Place*

## 15

Filed *APR 5 - 1922* *ROBERT R. KRAUTER*  
 Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 3<sup>rd</sup> 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Feb. 26, 1922*, to *April 3<sup>rd</sup> 1922*, that I last saw him alive on *April 3<sup>rd</sup> 1922*, and that death occurred, on the date stated above, at *2<sup>25</sup> A.M.*  
 The CAUSE OF DEATH\* was as follows:  
*Pneumonia & emphysema*

(duration) yrs. mos. *47* ds.  
 CONTRIBUTORY *Pericarditis (myocardial infarction)*  
 (Secondary) (duration) yrs. mos. *30* ds.

18 Where was disease contracted if not at place of death? *1631 Eutaw Place (home)*  
*2-25-22*

Did an operation precede death? *2* Date of *3-20-22*

Was there an autopsy? *Therapeutic drainage of*

What test confirmed diagnosis? *1st pleural cavity - pericardium*

(Signed) *Paul H. Sutton*, M. D.

, 19 (Address) *Union Memorial Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Green Mount Cemetery - Apr 5, 1922*

20 UNDERTAKER ADDRESS

*STEWART & MOWEN COMPANY* *108 W. NORTH AVE.*  
 (WILLIAM F. WOODEN, Successor)

## HEALTH DEPARTMENT—CITY OF BALTIMORE

63160

## CERTIFICATE OF DEATH.

31 D 63160

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *2005 Fleet*ST., *V*

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Henry Williams*(a) RESIDENCE NO. *2005 Fleet*

(Usual place of abode)

ST.,

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Aug. 14, 1890*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*31**7**20*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer 040*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Lea Shop*9 BIRTHPLACE (city or town)  
(State or country)*Baltimore  
Md.*10 NAME OF FATHER *Thomas Williams*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Wales*12 MAIDEN NAME OF MOTHER *Elizabeth Schaefer*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Germany*

14

Informant  
(Address)*Elizabeth Williams  
2005 Fleet St*

15

APR 5 - 1922 ROBERT R. KRAUTER,  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 3 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*March 20, 1922, to April 3, 1922,*that I last saw him alive on *April 2, 1922,*and that death occurred, on the date stated above, at *4:45 A. m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Phthisis Pulmonalis  
(Tuberculosis)*(duration) *2* yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *not to my knowledge*(Signed) *John H. Rehberger*, M. D., 19 *Address 1709 Alameda St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mount Carmel Cem**April 6 1922*

20 UNDERTAKER

ADDRESS

*The Sanders Sons**1200 Pk*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 63161

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 63161

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *701 S. Ellwood Ave.* ST.,

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Agnes Mattes*(a) RESIDENCE NO. *701 S. Ellwood Ave.* ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *43* yrs. mos. ds.How long in U. S., if of foreign birth? *43* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced, (write the word)

*Widow*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of*John Mattes*6 DATE OF BIRTH (month, day, and year) *May 29-1845*

7 AGE

Years

Months

Days

If LESS than  
t day, hrs  
or min.*76**10**5*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

*at home*

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

*Germany*

10 NAME OF FATHER

*John Reissig*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Germany*

14

Informant

(Address)

*Rev. Frank Mattes**Primer View P.O. Ill.*

15

Filed

*APR 5 - 1922*

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 3<sup>rd</sup> 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*23 Mar*, 1922, to *2<sup>nd</sup> Mar*, 1922.that I last saw her alive on *2 Mar*, 1922.and that death occurred, on the date stated above, at *2.00 P.* m.

The CAUSE OF DEATH\* was as follows:

*Lobar pneumonia*

(duration)

yrs.

mos

*10*

ds.

CONTRIBUTORY  
(Secondary)*Saul*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

*W. T. Mott* M. D.

, 19

(Address)

*301 S. Ellwood*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

 *Sacred Trust Cem.*

DATE OF BURIAL

*April 6 1922*

20 UNDERTAKER

*Lilly & Zailer*

ADDRESS

*403 S. M. St.*



D 63162

HEALTH DEPARTMENT—CITY OF BALTIMORE

63162

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2505 Mc Elderry*)

ST.:

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mina L. James*(a) RESIDENCE. NO. *2505 Mc Elderry*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *5* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Alick James*6 DATE OF BIRTH (month, day, and year) *June 14/1859*7 AGE Years *62* Months *9* Days *—* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Filghinans Island* (State or country) *Salisbury, Md.*10 NAME OF FATHER *Gibson*11 BIRTHPLACE OF FATHER (city or town) *Filghinans* (State or country) *Md.*12 MAIDEN NAME OF MOTHER *Williams*13 BIRTHPLACE OF MOTHER (city or town) *Filghinans* (State or country)14 Informant *Mrs. R. Rishel* (Address) *2505 Mc Elderry St.*15 Filed *APR 5 - 1922* ROBERT R. KRAUTER, Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 4* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *Mar 15*, 19*22*, to *Apr 3*, 19*22*, that I last saw *her* alive on *Apr 3*, 19*22*, and that death occurred, on the date stated above, at *7:30 a. m.*

The CAUSE OF DEATH was as follows:

*Influenza*(duration) yrs. mos. *18* ds.CONTRIBUTORY *Pneumonia* (Secondary)(duration) yrs. mos. *14* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Edward J. Howard*, M. D., 19 (Address) *821 N. Patterson Park Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Filghinans Island* *April 5 1922*20 UNDERTAKER *Salisbury Co. Md.* ADDRESS *for J. M. 156 N. Luzerne Ave.*

TION is very important. See instructions on back of certificates.

D 63163

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63163

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Lambert &amp; Greene ST.

WARD)

2-FULL NAME

Baby Davis

(a) RESIDENCE NO.

301 Hartford Rd.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 3-1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore  
Maryland

10 NAME OF FATHER

Columbus A. Davis

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore  
Maryland

12 MAIDEN NAME OF MOTHER

Edith P. Robert

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore  
Maryland

14

Informant (Address)

Edith P. Davis  
301 Hartford Rd.

15

Filed

APR 5 - 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

April 3 1922 to April 3 1922

that I last saw her alive on April 3 1922

and that death occurred, on the date stated above, at 11<sup>30</sup> A. M.

The CAUSE OF DEATH\* was as follows:

Prematurity  
(30 weeks gestation)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Maternal placenta Praevia

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

Address University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Landon Park Cemetery

April 5 1922

UNDERTAKER

ADDRESS

Johannah Carver

946 Ariguita

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63164

## CERTIFICATE OF DEATH.

D 63164

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4311 Ready ave ST. 27 WARD)

## 2-FULL NAME

Edward Sickel

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE No.

4311 Ready ave

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 8 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 6<sup>th</sup> 18757 AGE Years 47 Months 28 Days 28 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Principal of School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Louis D Sickel

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Mary E Orth

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

## 14

Informant (Address)

Mary E Sickel  
4311 Ready ave

## 15

APR 5 - 1922

ROBERT A. KRAUTER,

Burial Permit Officer

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 3, 1922

17

I HEREBY CERTIFY, That I attended deceased from Mar. 27, 1922 to Apr. 3, 1922.that I last saw him alive on Apr. 3, 1922.and that death occurred, on the date stated above, at 330 P. m.

The CAUSE OF DEATH\* was as follows:

Aquina pectoris

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of deathDid an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) C. D. Greenman, M. D.4/4/1922 (Address) 3949 Greenmount Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore Cemetery

DATE OF BURIAL

Apr 6<sup>th</sup> 1922

20 UNDERTAKER

George Schilling & Sons

ADDRESS

4126 E. Mount Airy

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT--CITY OF BALTIMORE

D 63165

## CERTIFICATE OF DEATH

100-001V

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2706 Harford Ave ST. 9 WARD)

2-FULL NAME

George Ramming

(If death occurred in a hospital or institution, give its NAME instead of street and number and room No. 18.)

(Residence in Baltimore: No. 2706 Harford Ave St. 60 yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

August 3, 1861

7-AGE

60 8

If LESS than 1 day, hrs., or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Merchant 145  
General Merchant

9-BIRTHPLACE  
(State or country)

Baltimore

10-NAME OF FATHER

John Michael Ramming

11-BIRTHPLACE OF FATHER  
(State or country)

Bararia

12-MAIDEN NAME OF MOTHER

Catherine Weyrmiller

13-BIRTHPLACE OF MOTHER  
(State or country)

Bararia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mar. 6, 1922

(Address)

1445 E. Lombard St.

15-

APR 5 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

April 3, 1922

17 I HEREBY CERTIFY, That I attended deceased from

Mar. 25, 1922, to, Apr. 2, 1922,

that I saw him alive on April 2, 1922,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH\* was as follows:

BronchoPneumonia

(Duration) yrs. mos. ds. 15

Contributory  
(SECONDARY)

(Duration) yrs. mos. ds. 7

(Signed) M. K. Krauter M. D.

April 3, 1922 [Address] 1445 E. Lombard St.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Baltimore Cemetery

DATE OF BURIAL

April 6th 1922

20-UNDERTAKER

George Schilling & Sons

ADDRESS

1126 E. Monument St.





## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63167

## CERTIFICATE OF DEATH.

REGISTERED NO.

D 63167

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 E. Monument ST.: 7 WARD)

## 2-FULL NAME Theodore Schmitz

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 1710 E. Monument ST.: WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 8 mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Mary Schmitz

6 DATE OF BIRTH (month, day, and year)

July 6, 1854

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

67

8

28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Maryland

(State or country)

10 NAME OF FATHER John Schmitz

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14

Informant

(Address)

Mrs. Ann Schmitz  
701 N. Kenwood Ave.

15

APR 5 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1922, to April 3, 1922.

that I last saw him alive on April 2, 1922.

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis

CONTRIBUTORY (Secondary)

(duration) 8 yrs. mos. ds.

Cordiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

Wm J Schmitz

M. D.

Apr 2 1922 Address 701 N. Kenwood Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral

April 6 1922

20 UNDERTAKER

ADDRESS

William E. Schaeffer 816 Monument

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63168

D 63168

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 227 G. Heath

ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME John Edelmann

(a) RESIDENCE. NO. 227 G. Heath St.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or ~~Married~~ (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Edelmann

6 DATE OF BIRTH (month, day, and year) Feb 3, 1957

7 AGE

65

Years

Months

Days

If LESS than 1 day, hrs. or min.

1 29

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Box maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto.

10 NAME OF FATHER Val Edelmann

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER Louise Kange

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Wm. Edelmann 227 G. Heath St.

15

APR 5 - 1922

ROBERT H. KRAUTER Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 2 1922

17

I HEREBY CERTIFY, That I attended deceased from

MAR 20, 1922, to April 1, 1922

that I last saw him alive on April 1, 1922.

and that death occurred, on the date stated above, at A. M.

The CAUSE OF DEATH was as follows:

Acute Cardiac dilatation

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. Chronic Nephritis

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [Signature] M. D.

44 19 7 (Address) [Signature]

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cedar Hill Cem, Apr 5 1922

20 UNDERTAKER

ADDRESS

Margaret G. Glynn 1422 Right

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63169

D 63169

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

FILE

APR 5 - 1922 ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Mar 12, 1922, to Apr 2, 1922,

that I last saw him alive on Apr 2, 1922,

and that death occurred, on the date stated above, at

The CAUSE OF DEATH was as follows:

Heart Cachexia Sclerotic

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

19 Address

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63170

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *First Ave, Hilldale.* ST. *28* WARD)

2-FULL NAME *Emily J. Stinson*

(Residence in Baltimore: No. *First Ave, Hilldale*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. *16* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH, *Doyle Hunt, 1855*  
(Month) (Day) (Year)

7-AGE, *67* yrs. mos. ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *Housekeeper*  
(b) General nature of industry, business, or establishment in which employed (or employer). *000*

9-BIRTHPLACE, (State or Country). *Savage, Md.*

10-NAME OF FATHER. *? Becker*

11-BIRTHPLACE OF FATHER (State or Country). *Unknown*

12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country). *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Alberta Corbin*

(Address) *Forest Ave, Hilldale*

15- *APR 5 - 1922* *ROBERT R. KRAUTER,*  
Filed Registrar.

COHONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 3, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest, and that said deceased came to death on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
*Cerebral hemorrhage*  
(Duration) yrs. mos. ds.  
CONTRIBUTORY (Secondary) *no history*  
(Signed) *J. T. Hannon* M. D.  
*April 5, 1922* Address *5002 Edgewood Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).  
At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, *Woodlawn* DATE OF BURIAL, *4-5-1922*

20-UNDERTAKER *Henry Brannings* ADDRESS *17 N. Silverside St*

D 63171  
134899

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

40 D 63171

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (NO. 100) JOHNS HOPKINS HOSPITAL, 9 WARD)

## 2. FULL NAME

Maisy Kelly

## (a) RESIDENCE NO.

1647 Monument St. City

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female Colored Widowed

5a If married, widowed, or divorced

husband or wife of

William A. Kelly (friend)  
1647 Monument St.

6 DATE OF BIRTH (month, day, and year)

Feb. 1, 1884

7 AGE

38

Years

Months

2

Days

2

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

Steve Austin

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

Laura Holmes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

APR 5 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Salsbury, N.C.

20 UNDERTAKER

John W. Henderson

DATE OF BURIAL

April 9, 1922

ADDRESS

1502

C. M. M. M. M.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 31, 1922, to April 3, 1922.

that I last saw her alive on April 9, 1922.

and that death occurred, on the date stated above, at 6:00 P.M.

The CAUSE OF DEATH\* was as follows:

Question: dysentery, vomiting, severe dehydration, prostration. Part of trouble - Peritonitis

(duration) - yrs. - mos. 3 ds.

CONTRIBUTORY ?

(Secondary) (duration) - yrs. - mos. - ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of April 1, 1922

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Karl H. M. M. M., M. D.

, 19 (Address) John W. Henderson

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

Missing  
#①63172

D 63173 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

Registered No. C. 66 D 63173

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *Baltimore Hospital-26* St. *26* Ward)

## 2-FULL NAME

(Residence in Baltimore: No. *Not known* St.; yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX, *M* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, (Month) (Day) (Year)

7-AGE, *62* yrs., mos., ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *Laborer*  
(b) General nature of industry, business, or establishment in which employed (or employer), *040*9-BIRTHPLACE, (State or Country), *Ireland*

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Wise*

(Address),

15-

Filed *APR 5 - 1922* *ROBERT A. KRAUTER* Registrar.

THE MORQUE

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Signed) *W. J. ...* M. D. (Coroner.) 192 (Address) *...*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER, ADDRESS, *1922*

is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63174

CERTIFICATE OF DEATH.

D 63174

## 1-PLACE OF DEATH

City of BALTIMORE: (No. 306 4 Gilman

St.

Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John German

(Residence in Baltimore: No. 306 4 Gilman

St.; yrs.....mos.....ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. White 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH. (Month) (Day) (Year)

7-AGE. About 64 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER. (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Colston

(Address) 306 4 Gilman

15-APR 5 - 1922

UNIVERSITY OF MARYLAND.

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 30, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an. Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said. Inquest, autopsy or inquiry. And that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Epileptic Convulsion + turned on his face + smothered to death - pillow accident (Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 2 yrs. mos. ds. (Signed) James M. Denton M. D. (Coroner) Mar 30 1922 (Address) 700 E. Chesebrough

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL.

20-UNDERTAKER.

Commissioner Health, ADDRESS 1922

APR 5 1922

Is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63175

CERTIFICATE OF DEATH

169 D 63175

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *9*)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No. *unknown*)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE,

*White*5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)*Single*

6-DATE OF BIRTH,

....., 1.....  
(Month) (Day) (Year)

7-AGE,

71 yrs. .... mos. .... ds. If LESS than 1 day,  
..... hrs. or .... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

*Labour*9-BIRTHPLACE,  
(State or Country),*unknown*

10-NAME OF FATHER,

*unknown*11-BIRTHPLACE OF FATHER  
(State or Country),

12-MAIDEN NAME OF MOTHER

*unknown*13-BIRTHPLACE OF MOTHER  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-

Filed....., 1911.....

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Mar 26, 1912*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held on.....  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said.....  
(Inquest, au-..... and that said deceased came to..... death  
(Inquest or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Pneumonia*  
*Specified by pumping*  
*in from field*

CONTRIBUTOR (Secondary) .....

(Signed)..... M. D.

5-27, 1912 (Address).....

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

UNIVERSITY OF MARYLAND.

20-UNDERTAKER

*Commissioner Health,*

ADDRESS

*APR 1912*

THE MORGUE.

Wm. K. WOODALL

D 63176

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

90 D 63176

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

608 N. Fremont ST. 16

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Elizabeth S. Watkins

(a) RESIDENCE. No.

608 N. Fremont ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

65 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Nicholas A. Watkins

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

67 8 19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Stone

(b) General nature of industry, business, or establishment in which employed (or employer)

job

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ohio

10 NAME OF FATHER

John Riley

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Not Known

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

" "

14

Informant (Address)

H R Watkins 608 N. Fremont St.

15 Filed

19

HUBERT B. KNOTLEY,

Registrar

APR 5 - 1922

Burial Permit Clerk,

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) APR 4 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 25, 1922, to Apr. 4, 1922.

That I last saw her alive on Mar 31, 1922.

and that death occurred, on the date stated above, at 10:30 a m.

The CAUSE OF DEATH\* was as follows:

General Break-down due to age chronic rheumatism and Myocardial degeneration

(duration) 2 yrs. 21 mos. - ds.

CONTRIBUTORY (Secondary)

General Anemia (duration) 2 yrs. 2 mos. - ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? - Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

4/5, 1922 Address)

Clinical Wm. Cole, M. D. 2707 Emerson Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park

APR 6 1922

20 UNDERTAKER

ADDRESS

Geo W Little 2700 Edmondson av

D 63177

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63177

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1204 William*ST., *24* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*George Eisel Sr.*

## (a) RESIDENCE NO.

*1204 William*ST., *24* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *65* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Married*5a ~~Married, widowed, or divorced~~

HUSBAND of

~~(or WIFE of)~~*Christina Eisel*

## 6 DATE OF BIRTH (month, day, and year)

*Nov 30 1834*

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*87**4**4*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

*040*

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Germany*

## 10 NAME OF FATHER

*not known*

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Germany*

## 12 MAIDEN NAME OF MOTHER

*not known*

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Germany*

## 14

Informant

(Address)

*Christina Eisel (wife)*  
*1204 William St*

## 15

APR 5 - 1922

ROBERT R. KRAUTER,  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*April 3<sup>rd</sup> 1922*

## 17

I HEREBY CERTIFY, That I attended deceased from

*October 4, 1921, to April 3, 1922.*that I last saw him alive on *April 3, 1922.*and that death occurred, on the date stated above, at *10 45 A.* m.

The CAUSE OF DEATH\* was as follows:

*Interstitial Nephritis*(duration) *2* yrs. *4* mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death? *1204 William St.*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Urinary analysis*(Signed) *W. B. Brackley* M. D., 19 (Address) *1328 S. Charles St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

*Holy Cross A.C.C.**4-6 1922*

## 20 UNDERTAKER

## ADDRESS

*E. B. Harber**145 E. 2nd St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



D 63178

HEALTH DEPARTMENT—CITY OF BALTIMORE D 63178

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 Palapser ST., 100-001 WARD)

## 2-FULL NAME Elizabeth Hartman

(a) RESIDENCE NO. 100 Palapser ST.,

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds.

How long in U. S., if of foreign birth? 40 yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Hartman

6 DATE OF BIRTH (month, day, and year) Dec 22 1877

7 AGE

Years 77

Months 3

Days 13

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Andrew Dobie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Madeline Wahr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14

Informant Elizabeth Langenbach

(Address) 100 Palapser St.

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1922

17 I HEREBY CERTIFY, That I attended deceased from

March 30, 1922, to April 7, 1922

that I last saw him alive on April 3, 1922

and that death occurred, on the date stated above, at 2-30 a.m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

19

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 63179

## HEALTH DEPARTMENT-CITY OF BALTIMORE

## CERTIFICATE OF DEATH

D 63179

## PLACE OF DEATH

CITY OF BALTIMORE (No.

2514 E Preston

ST.

WARD)

## FULL NAME

Grant E. Harper

(Residence in Baltimore: No.

2514 E Preston

St. 30 yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

COLOR OR RACE

White

SINGLE,  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

Married

DATE OF BIRTH

February 28, 1865

(Month)

(Day)

(Year)

AGE

57 yrs.

1 mos.

3 ds.

If LESS than  
1 day, hrs.  
or min.?

OCCUPATION

(a) Trade, profession, or  
particular kind of work  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Butcher

Grocery Store

BIRTHPLACE

(State or country)

Ohio.

10 NAME OF  
FATHER

Chas. N. Harper.

11 BIRTHPLACE  
OF FATHER  
(State or country)

Ohio

12 MAIDEN NAME  
OF MOTHER

Catherine Schunaberger

13 BIRTHPLACE  
OF MOTHER  
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

May Harper

(Address)

2514 E Preston

15.

Robert P. Harrison,

Filed

191

1922

Burial Permit Clerk

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 3<sup>rd</sup>, 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY That I attended deceased from

July 12, 1912, to April 3, 1922

that I saw him alive on April 3, 1922

and that death occurred, on the date stated above, at 9:45 P.M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Stomach

(Duration) 8 yrs. mos. ds.

Contributory  
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Thos. A. Stevens M.D.

4/4, 1922 (Address) 2878 Harford Rd.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,  
state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL.18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woodlawn Cem.

4/6/22, 191

20. UNDERTAKER

ADDRESS

J. J. [unclear]

1318 [unclear]

10. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63180

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1609 Cole* ST.: *19* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Baby Cassup*(Residence in Baltimore: No. *1609 Cole St* St.: ..... yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE. *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*  
(Write the word.)

6-DATE OF BIRTH. *April 4*, 1922  
(Month) (Day) (Year)

7-AGE, ..... yrs. .... mos. .... ds. *4* hrs. or .... min. *1*  
If LESS than 1 day.

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. ....  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Baltimore*

10-NAME OF FATHER *Andrew Cassup*  
11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*  
12-MAIDEN NAME OF MOTHER *May Nash*  
13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Andrew Cassup*(Address) *1609 Cole St. City*

15- Robert P. Harrison,  
Filed..... 191..... Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *April 4*, 1922  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *4/4/22* 191, to *4/4* 1922, that I saw him alive on *April 4* 191, and that death occurred, on the date stated above, at *3 P* m. The CAUSE OF DEATH\* was as follows:

*From infant Jotus*  
(Duration)..... yrs. .... mos. .... ds.

CONTRIBUTORY.....  
(Secondary)

(Signed) *H. J. Fisher* M. D.  
*4/5/1922* (Address) *1901 E. Ave. St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*Baby Redeemer Church* *April 2, 1922*

20-UNDERTAKER ADDRESS

*Jos. Hegnam Son* *Coca, Hamburg*

important. See instructions on back of certificate.

R5-1922 Burial Permit Clerk.

D 63181

HEALTH DEPARTMENT—CITY OF BALTIMORE D 63181

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

South Balt. General Hospital 144

REGISTERED NO.

CITY OF BALTIMORE (No.

1213 Light St.

ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs Bertha Thalheimer

(a) RESIDENCE. NO.

109 Park Ave Wilhelm St.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 1 mos. 3

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

(HUSBAND) of  
(or) WIFE of

Raymond J. Thalheimer

6 DATE OF BIRTH (month, day, and year)

Oct. 29-1884

7 AGE

38

Years

1

Months

Days

3

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Balto Md

10 NAME OF FATHER

Frank L. Habicht

PARENTS

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

Balto Md

12 MAIDEN NAME OF MOTHER

Amelia Weiskner

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

Balto Md.

14

Informant  
(Address)Raymond J. Thalheimer  
109 Park Ave Wilhelm St.

15

Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

April 3 1922, to April 3 1922,

that I last saw her alive on April 3 1922,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH\* was as follows:

Premature separation of placenta

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of April 3, 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph Pokorny M. D.

19 (Address) South Balt. Gen. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cemetery April 6 1922

20 UNDERTAKER

ADDRESS

James Dignan &amp; Son

1400 S. E. Ave.

TION is very important. See instructions on back of certificates.

R5-1922

Burial Permits Clerk.



D 63182

## HEALTH DEPARTMENT—CITY OF BALTIMORE

199D 63182

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE (No. 1121 n. Gay

ST. 8

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Annie D. Casey.

(Residence in Baltimore: No. 1121 n. Gay.

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)

6-DATE OF BIRTH,

Aug

1, 1891

7-AGE,

30 yrs. 8 mos. 2 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

House work. 131

9-BIRTHPLACE, (State or Country).

Baltimore

10-NAME OF FATHER,

Charles Mauer

11-BIRTHPLACE OF FATHER (State or Country).

Baltimore

12-MAIDEN NAME OF MOTHER

Julia Brent

13-BIRTHPLACE OF MOTHER (State or Country).

Newark N.J.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Julia Mauer

(Address)

1121 n. Gay

15-

Robert P. Harrison,

Filed

191

5-1922

Burial Permit Clerk.

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April

3, 1912

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy and that said deceased came to death

(on the day stated above.)

The CAUSE OF DEATH\* was as follows:

Aspiration of mucus.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. H. Foster, M. D.

(Coroner) 4-5-1912 Address) 4-5-1912

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Woodlawn Cem

April 6, 1912

20-UNDERTAKER

ADDRESS

John E. Branch

802 Madison

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63183

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1629 N Bradford* ST.: *8* WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Karl Robl*(a) RESIDENCE. No. *1629 N Bradford* ST., *8* WARD. *Wash, D. C.*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. *9* mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*W*

5 Single, Married, Widowed,

or Divorced (write the word)

*Married*5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Dec 8 1869*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.*51**3*

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work*Butcher 013*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Germany*

10 NAME OF FATHER

*Unknown*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Germany*

14

Informant

(Address)

*Mary A Bausch*  
*1629 N Bradford St*

15

Filed

*Robert P. Harrison,*

Registrar

1922

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 4* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

*Nov 25*, 19*21*, to *April 4*, 19*22*,that I last saw him alive on *April 3*, 19*22*,and that death occurred, on the date stated above, at *7:05* a.m.

The CAUSE OF DEATH\* was as follows:

*Gastric Carcinoma*(duration) *2* yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? *Wash D.C.*Did an operation precede death? *Yes* Date of operation *7/10*Was there an autopsy? *No*What test confirmed diagnosis? *None*(Signed) *D. P. Herzog M.D.* M. D.1922 (Address) *1305 N Patterson PK Ave*\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Redeemer**April 7 1922*

20 UNDERTAKER

ADDRESS

*Wendell Duffel & Son**318 N*

D 63184

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63184

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 808 N. Wolfe ST., WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

George W. A. Neilson

## (a) RESIDENCE NO.

808 N. Wolfe

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs 10 mos 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Mary A. Neilson

## 6 DATE OF BIRTH (month, day, and year)

May 8, 1846

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

75

10

26

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

015

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

## 10 NAME OF FATHER

Jos. R. Neilson

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

## 12 MAIDEN NAME OF MOTHER

Katherine Mac Abey

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

## 14

Informant (Address)

Mary A. Neilson 808 N. Wolfe

5-1922

Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 5, 1922

## 17

I HEREBY CERTIFY, That I attended deceased from July 10, 1921, to Apr 5, 1922, that I last saw him alive on Mar 11, 1922, and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH\* was as follows:

## CONTRIBUTORY (Secondary)

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. R. Tumbleson, M. D.

451922 (Address) 2013 Banks

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

## DATE OF BURIAL

Holy Redeemer

April 8, 1922

## FUNERAL

Zirklen &amp; Zirklen

## ADDRESS

1739 Eager

D 63185 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63185

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 325-24 21<sup>st</sup> ST. 17 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Bessie Elizabeth Kramer

## (a) RESIDENCE NO.

325-24 21<sup>st</sup>

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yr. 3 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

F

## 4 COLOR OR RACE

W

## 5 Single, Married, Widowed, or Divorced, (write the word)

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Dec 1 1918

## 7 AGE

3

4

3

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore

## 10 NAME OF FATHER

Emory H. Kramer

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

## 12 MAIDEN NAME OF MOTHER

Maud Brown

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ash &amp; Co

## 14

Informant (Address)

Emory H. Kramer 325-24 21<sup>st</sup>

## 15

Filed

Robert E. Harrison

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 7 1922

## 17

I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to April 7, 1922, that I last saw h. or alive on April 4, 1922.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Congestive Failure

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Lee Richardson M. D.

1922

(Address)

112 U. 25th St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

W. C. Cork

A. S. K.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

5-1922

Burial Permit Clerk



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

D 63186

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63186

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *University Hospital* ST. *18* WARD)

2-FULL NAME

*Thomas J. Lewis*

(Residence in Baltimore: No. *116 N Poppleton St*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

*Life* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*Male*

4-COLOR OR RACE,

*White*

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

*Widowed*

6-DATE OF BIRTH,

*Don't know, 1*

7-AGE,

*60*

IF LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Retired Soldier*

9-BIRTHPLACE,

(State or Country),

*Baltimore*

10-NAME OF FATHER,

*Thomas Lewis*

11-BIRTHPLACE OF FATHER

(State or Country),

*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*

13-BIRTHPLACE OF MOTHER

(State or Country),

*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Charles H. Lewis*

(Address) *865 Hollins St.*

15-

Filed *Robert P. Lewis*

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*April 2, 1922*

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Acute Lobar Pneumonia*

CONTRIBUTORY (Secondary)

*Chronic Bronchitis*

(Signed) *W. H. Cook* M. D.

*5 1922* Address *112 N. Sanborn*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Baltimore Cemetery*

*April 6, 1922*

20-UNDERTAKER

*William Cook*

ADDRESS

*502 E. North Ave.*

5-1922

Period Death Clerk.

*History of gas stove near window. Wind blew light out  
Accidental inhalation illuminating gas. Autopsy showed  
lobar pneumonia due to inhalation gas.*

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*,

*peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia," (merely symptomatic), "At-rophy," "Collapse," "Coma," "Convulsions," "De-bility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite dis-ease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septichæmia," "PUERP-ERAL peritonitis," etc. State cause for which sur-gical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Ex-amples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homi-cide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional in-formation which may give any of the following diseases, without explanation as the sole cause of death:

*Abortion*, *Hæmorrhage*, *Meningitis*, *Phlebitis*,  
*Cellulitis*, *Gangrene*, *Miscarriage*, *Pyæmia*,  
*Childbirth*, *Gastritis*, *Necrosis*, *Septicæmia*,  
*Convulsions*, *Erysipelas*, *Peritonitis*, *Tetanus*.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63187

## CERTIFICATE OF DEATH.

31 D 63187

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *820 Blooney* ST.; *18* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *820 Blooney* St.; *32* yrs., *32* mos., *32* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Male*

## 4-COLOR OR RACE

*Wht*5-SINGLE, *Single*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

*Nov* *14*, *1890*  
(Month) (Day) (Year)

## 7-AGE,

*32* yrs., *32* mos., *32* ds.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Housekeeper*(b) General nature of industry, business, or establishment in which employed (or employer) *045*9-BIRTHPLACE,  
(State or Country),*Ba*

## 10-NAME OF FATHER,

*Wm. F. Lora*11-BIRTHPLACE OF FATHER  
(State or Country),*Harvard Co*

## 12-MAIDEN NAME OF MOTHER

*Mary Grender*13-BIRTHPLACE OF MOTHER  
(State or Country),*Ba*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Herma Lora*(Address) *820 Blooney St*

## 15-

Robert P. Harrison, Registrar.

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Apr. 4*, *1912*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Mar 4* *1912*, to *Apr 4* *1912*,that I saw h... alive on *Mar 3* *1912*,and that death occurred, on the date stated above, at *10 A* m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis*(Duration) *6* yrs., *6* mos., *6* ds.CONTRIBUTORY  
(Secondary)(Duration) *6* yrs., *6* mos., *6* ds.(Signed) *J. H. Woodward* M. D.*1114*, *1912* (Address) *909 W. 7th St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *32* yrs., *32* mos., *32* ds. In the State *32* yrs., *32* mos., *32* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*New Cathedral**4* *6*, *1912*

## 20-UNDERTAKER

ADDRESS *117 N**H. C. Branning, Son & Schuchert*

CAUSE OF DEATH IN PARTIALITY OF CERTIFICATE. See instructions on back of certificate.

R5-1972

D 63188

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63188

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *635 N. Carrollton Ave.* ST. *7* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *John Rhodes*(a) RESIDENCE, No. *625 N. Carrollton Ave.* ST. *7* WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *14* yrs. mos. ds.How long in U. S., if of foreign birth? *36* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Ann Rhodes*6 DATE OF BIRTH (month, day, and year) *unknown*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Commander*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Carrollton Baptist Church*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *England*10 NAME OF FATHER *John Rhodes*11 BIRTHPLACE OF FATHER (city or town) (State or country) *England*12 MAIDEN NAME OF MOTHER *Ann Rhodes*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *England*

14

Informant (Address)

*Mrs. Mary Rhodes  
625 N. Carrollton Ave.*

R5 - 1922

*Robert P. Harrison,*

Registrar

*Death Permit Clerk.*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 5* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

*Sept 5*, 19*21*, to *April 5*, 19*22*,that I last saw him alive on *April 2*, 19*22*,and that death occurred, on the date stated above, at *Case 2* m.

The CAUSE OF DEATH\* was as follows:

*Salmonella of Bladder  
Carcinoma*(duration) yrs. *7* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. *4* mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Specimen Microscopic*(Signed) *J. P. Harrison*, M. D., 19 (Address) *625 N. Carrollton Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Western**4-6-1922*

20 UNDERTAKER

ADDRESS *517 N.**H. B. Hammond**Schmidt*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63189

## CERTIFICATE OF DEATH.

D 63189

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 N Franklin ST.: 18 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Julia Geary

## (a) RESIDENCE. NO.

1208 N. Franklin ST.,

## WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

58 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female White

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced (write the word)

Widow

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofJohn Geary

## 6 DATE OF BIRTH (month, day, year)

Autumn 1848

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.74.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Ireland

## 10 NAME OF FATHER

John Geary

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

## 12 MAIDEN NAME OF MOTHER

Julia Bone

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

## 14

Informant  
(Address)Mrs. Marie B. Hill  
1208 N. Franklin St.

## 15

Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 4 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

Nov 1, 1921, to April 4, 1922.that I last saw her alive on April 4, 1922.

and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Arteriosclerosis(duration) 2 yrs. 4 mos. 4 ds.

## CONTRIBUTORY (Secondary)

Cerebral Thrombosis(duration) \_\_\_\_\_ yrs. 4 mos. 4 ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of \_\_\_\_\_Was there an autopsy? NoWhat test confirmed diagnosis? Physical(Signed) E. W. C. Coolahan, M. D.Address) 24 N. Fulton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

New Cathedral4/7 1922

## 20 UNDERTAKER

## ADDRESS

H. C. Branning58 Poppleton

TION is very important. See instructions on back of certificates.

5-1922

Burial Permit Clerk.

D 63190 Co.—1000 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11617. Mount

ST.: 16 WARD)

### REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

John Hopkins

### (a) RESIDENCE. No.

11617. Mount St.

ST., WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos.

ds. How long in U. S., if of foreign birth 4 yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

#### 3 SEX

male

#### 4 COLOR OR RACE

Colored

#### 5 Single, Married, Widowed, or Divorced (write the word)

Single

#### 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

#### 6 DATE OF BIRTH (month, day, and year)

Unknown

#### 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

39

#### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Contractor

(c) Name of employer

Hudson Cement Co.

#### 9 BIRTHPLACE (city or town) (State or country)

Virginia

#### 10 NAME OF FATHER

Samuel Hopkins

#### 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

#### 12 MAIDEN NAME OF MOTHER

Lily Johnson

#### 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

#### 14

Informant

(Address) Wm. Hopkins, Brother

#### 15

APR 6 - 1922

ROBERT R. KRAUTER,

Burial Permit Registrar

### MEDICAL CERTIFICATE OF DEATH

#### 16 DATE OF DEATH (month, day, and year)

4 - 4 - 1922

#### 17

I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to April 4, 1922, that I last saw him alive on April 4, 1922, and that death occurred, on the date stated above, at 4:40 p.m. The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

#### CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

#### 18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George C. Page, M. D.

, 19 (Address) 17207. Mount St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

#### 19 PLACE OF BURIAL, CREMATION OR REMOVAL

#### DATE OF BURIAL

Wm. Hopkins

April 6 1922

#### 20 UNDERTAKER

#### ADDRESS

Edward R. Ringgold 1463 Ave.

tion is very important. See instructions on back of certificates.

D 63191

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63191

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 873 W LOUMBARD

ST.

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JOHN VELIVIS

(a) RESIDENCE. No. 873 W LOUMBARD

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs mos.

ds. How long in U. S., if of foreign birth? 27 yrs mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

MALE

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Know

7 AGE 49 Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Not Know

9 BIRTHPLACE (city or town) (State or country)

Lithuania

10 NAME OF FATHER John Velivis

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Lithuania

12 MAIDEN NAME OF MOTHER Rose Bursakas

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Lithuania

14

Informant Geo Velivis

(Address) 873 W Loubard St.

15

Filed

APR 8 1922 ROBERT R. KRAUTER Registrar

Burr: Parnell Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 April 1922

17

I HEREBY CERTIFY, That I attended deceased from 15 March, 1922, to 1 April, 1922, that I last saw him alive on 1 April, 1922, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH was as follows:

Chronic Interstitial Nephritis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Joseph Abramowitz M. D.

19 (Address) 6 M. S. Park St., Baltimore, Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer

4/ 7h 1922

20 UNDERTAKER

ADDRESS

John Grebliauckas

425 S Pa a

st

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63192

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *801 Lennox* ST.; *13* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Miss Charlotte E. Bonnell*(Residence in Baltimore: No. *801 Lennox st.*St. *38* yrs. \ mos. \ ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, *Single*  
MARRIED, WIDOWED, OR DIVORCED.  
(Write the word.)6-DATE OF BIRTH, *Jan 29*, *1842*  
(Month) (Day) (Year)7-AGE, *80* yrs. *2* mos. *6* ds. If LESS than 1 day,  
...hrs. or...min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *None*  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, *S. Carolina*  
(State or Country).10-NAME OF FATHER, *Capt Edw. Bonnell*11-BIRTHPLACE OF FATHER, *S. Carolina*  
(State or Country).12-MAIDEN NAME OF MOTHER, *Eliza Smith*13-BIRTHPLACE OF MOTHER, *S. Carolina*  
(State or Country).

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss Caroline Seiger*  
(Address) *801 Lennox st.*

15-

Filed *APR 6 - 1922* 191... *Burial Permit Clerk*  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Apr 4*, *1922*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Reby 26<sup>th</sup>* 1922, to *Apr 4<sup>th</sup>* 1922, that I saw her alive on *Apr 4<sup>th</sup>* 1922, and that death occurred, on the date stated above, at *11 P.m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral apoplexy*  
*with paralysis of throat*  
(Duration) *7* yrs. *7* mos. *7* ds.CONTRIBUTORY *arteriosclerosis*  
(Secondary) (Duration) *5* yrs. *7* mos. *7* ds.(Signed) *Eugene Douglas* M. D.  
*Apr 5<sup>th</sup>* 1922 (Address) *830 W. North St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

## DATE OF BURIAL.

*Green Park Cem.* *7/8/22* 191...

## 20-UNDERTAKER

## ADDRESS

*H. J. Schuler & Sons* *1000 N. E. St.*

important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63193

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1304 N. Lafayette St. WARD)

## 2. FULL NAME

Helen Ellis Farmer

## (a) RESIDENCE NO.

1304 N. Lafayette St.

## WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Ernest Farmer

## 6 DATE OF BIRTH (month, day, and year)

Sep 13 - 1888

## 7 AGE

33

7

0

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

## 10 NAME OF FATHER

Edward B Simmons

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

## 12 MAIDEN NAME OF MOTHER

Estella Spangler

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

## 14

Informant  
(Address)Ernest Farmer  
1304 N. Lafayette St.

## 15

APR 6 - 1922

ROBERT R. CRAUTER,  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

Apr 4 1922

## 17 I HEREBY CERTIFY, That I attended deceased from

April 1, 1922, to April 4, 1922.

that I last saw him alive on April 4, 1922.

and that death occurred, on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH\* was as follows:

Acute Nephritis (f. Army  
Chloridosis).

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death?

1304 N. Lafayette St.

## Did an operation precede death?

Yes Date of April 3/22

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

Chloridosis  
W. W. W. M. D.  
Chloridosis

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

London Park

## DATE OF BURIAL

Apr 7 1922

## UNDERTAKER

Wm. J. Tucker &amp; Son

## ADDRESS

N. &amp; Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

D 63194

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63194

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 E. Woodland Av. ST. 27 WARD)

## 2. FULL NAME

Julien Leon Bowdre,

## (a) RESIDENCE

No. 125 E. Woodland Av. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 11 mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

A. Medora Bowdre

## 6 DATE OF BIRTH (month, day, and year)

Jan 22, 1868

## 7 AGE

Years

Months

Days

54 -

2

13

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Rights of way agent

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Telephone

(c) Name of employer

Ches. Potomac Tel. Co.

## 9 BIRTHPLACE (city or town)

Perry,

(State or country)

Georgia

## 10 NAME OF FATHER

Edward P. Bowdre

## 11 BIRTHPLACE OF FATHER (city or town)

unknown

(State or country)

Georgia

## 12 MAIDEN NAME OF MOTHER

Mary M. Ross

## 13 BIRTHPLACE OF MOTHER (city or town)

unknown

(State or country)

Georgia

## 14

Informant

Philip A. Bowdre

(Address)

125 E. Woodland Av. Baltimore

## 15

PHS-1000 19

ROBERT R. KRAUTER

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4 1922

17

I HEREBY CERTIFY, That I attended deceased from

Mar 22, 1922, to Apr 4, 1922

that I last saw him alive on Apr 4, 1922

and that death occurred, on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH\* was as follows:

Mitral Insufficiency

(duration) 15 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

Hypostatic Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Jno. D. Robert

M. D.

, 19

(Address) 2201 North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Greenmount Cem Apr 6, 1922

20 UNDERTAKER

ADDRESS

Wm J. McKee 2000 North Ave

D 63195

## HEALTH DEPARTMENT—CITY OF BALTIMORE

63195

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1423 E Pratt St. ST., 3 WARD)

## 2-FULL NAME

(a) RESIDENCE NO. 1423 E Pratt St. ST., 3 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 23 ds. How long in U. S., if of foreign birth? yrs. 7 mos. 23 ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 13 - 19217 AGE Years 7 Months 23 Days 23 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland10 NAME OF FATHER James Caplan11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland12 MAIDEN NAME OF MOTHER Lily Davis13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland14 Informant James Caplan (Address) 1423 E Pratt St.15 APR 6 - 1922 Robert H. Knauer Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/5 19 2217 I HEREBY CERTIFY, That I attended deceased from 4/5 19 22 to 4/5 19 22that I last saw him alive on 4/5 19 22and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH\* was as follows

Broncho PneumoniaCONTRIBUTORY (Secondary) Fracture (duration) yrs. 2 mos. 2 ds.(duration) yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry G. Olden M.D.Address 2210 E. Pratt St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Rehman Rosedale

DATE OF BURIAL

4/6 19 22

20 UNDERTAKER

Jack Lewis 1439 S. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63196

## CERTIFICATE OF DEATH.

90 D 63196

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2426 Callow Avenue ST. 13 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Porter

(a) RESIDENCE. No. 2426 Callow Avenue ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

John Wesley Porter

6 DATE OF BIRTH (month, day, and year) Feb. 17, 1851

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
71 1 17

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Churchill  
(State or country) Maryland

10 NAME OF FATHER Henry Walls

11 BIRTHPLACE OF FATHER (city or town) Churchill  
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah

13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)14 Informant Mrs. Mary V. Monroe  
(Address) 816 Olive St. St. Louis, Mo.

15 Filed APR 5 1922 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 3 1922

17

I HEREBY CERTIFY, That I attended deceased from March 29, 1922, to Apr 3, 1922

that I last saw her alive on Apr 3, 1922

and that death occurred, on the date stated above, at 2.30 A.M.

The CAUSE OF DEATH\* was as follows:

Mitral Insufficiency  
(duration) Unknown yrs. mon. ds.CONTRIBUTORY Hypostatic Pneumonia  
(Secondary) (duration) 1 yrs. mos. ds.18 Where was disease contracted  
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D. Ruber, M. D.

, 19 (Address) 4834 Park Heights Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Churchill, Maryland

4/6 1922

20 UNDERTAKER

ADDRESS

Henry W. Mears &amp; Son 805 N. Calvert

TION is very important. See instructions on back of certificates.

Via mail Del. &amp; Va. Railway's Steamship - Mrs. Mary V. Monroe, Escort.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63197

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1534 Fayette St.* WARD)

2-FULL NAME

(Residence in Baltimore: No. *6*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Female*

4-COLOR OR RACE,

*col.*

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word)

*Single*

6-DATE OF BIRTH,

*September 1*  
(Month) (Day) (Year)

7-AGE,

*13* yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

*School*

9-BIRTHPLACE,  
(State or Country),

*Balto*

10-NAME OF FATHER

*Gay, Keefar*

11-BIRTHPLACE OF FATHER  
(State or Country),

*Balto*

12-MAIDEN NAME OF MOTHER

*Mary Keefar*

13-BIRTHPLACE OF MOTHER  
(State or Country),

*Balto*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

APR 6 - 1922

191... ROBERT R. KRAUTER,

Registrar.  
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*April 3, 1922*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an...  
(Inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said...  
(Inquest, au-

*Inquest* find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Dysm. clarks coast  
fire while balding fire*  
(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. M. J. J.*  
(Coroner.)

(Address) *44 E. 1st St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

*Adams Cemetery*

DATE OF BURIAL,

*April 6, 1922*

20-UNDERTAKER

*Edward Ryan*

ADDRESS

*1631 Orleans St*

D 63198 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

57 D 63198

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1828 Alice Anna ST., 2 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Walters

(a) RESIDENCE No. 629 V. Durham ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John C. Walters

6 DATE OF BIRTH (month, day, and year) Feb. 23-1857

7 AGE Years 64 Months 1 Days 12 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Joseph Grimm

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Thressa Runkel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Margaret Seitz (Address) 1828 Alice Anna St.

15 APR 6-1922 ROBERT R. KRAUTER, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1922

17 I HEREBY CERTIFY, That I attended deceased from

Mar 20, 1922, to Apr 5, 1922,

that I last saw him alive on Apr 5, 1922,

and that death occurred, on the date stated above, at 2 A. M.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Walters, M. D.

19 (Address) 1710 Flat St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt. Carmel Cemetery April 8 1922

20 UNDERTAKER

ADDRESS

H. Jander &amp; Sons 1710 Flat St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63199

## CERTIFICATE OF DEATH.

159<sup>002</sup> D 63199

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 N. Mount ST., 19 WARD)2. FULL NAME Rose Carr(a) RESIDENCE NO. 24 N. Mount ST., \_\_\_\_\_ WARD \_\_\_\_\_

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓6 DATE OF BIRTH (month, day, and year) Feb 23, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 1 13

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Name good(b) General nature of industry, business, or establishment in which employed (or employer) ✓(c) Name of employer ✓9 BIRTHPLACE (city or town) Baltimore  
(State or country)10 NAME OF FATHER Carroll Carr11 BIRTHPLACE OF FATHER (city or town) Baltimore  
(State or country)12 MAIDEN NAME OF MOTHER Elizabeth Allen13 BIRTHPLACE OF MOTHER (city or town) Baltimore  
(State or country)

14

Informant  
(Address) Mrs C. Carr  
24 N. Mount St

15

APR 6 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 23, 1922 to April 5, 1922, that I last saw her alive on April 4, 1922, and that death occurred, on the date stated above, at 2.05 a.m.

The CAUSE OF DEATH\* was as follows:

Congenital Heart Disease(duration) yrs. 1 mos. 13 ds.CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓Did an operation precede death? ✓ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

(Signed) M. O'Neill M. D.4/6, 1922 (Address) 108 N. Fulton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Cathedral Ave.April 6 1922

20 UNDERTAKER

ADDRESS

Marjorie L. Hyman1422 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63200

## CERTIFICATE OF DEATH.

D 63200

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *617 N. Caroline* ST.;

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Thomas H. D. Wallace*(a) RESIDENCE. No. *617 N. Caroline* ST.,

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

1 yrs. 4 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *colored* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

#

6 DATE OF BIRTH (month, day, and year) *Nov. 11/1920*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *1 4*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Not any*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*10 NAME OF FATHER *Thomas F. Wallace*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Maryland*12 MAIDEN NAME OF MOTHER *Lillian E. Bell*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Balto. Maryland*14 Informant *Thomas F. Wallace*(Address) *617 N. Caroline St.*

15

Filed *APR 6 - 1922*

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-5* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

*April 1, 1922, to April 5, 1922,*that I last saw him alive on *April 4, 1922,*and that death occurred, on the date stated above, at *5.50 a.m.*

The CAUSE OF DEATH\* was as follows:

*Acute Meningitis*(duration) yrs. mos. *5* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*J. E. Thomas* M. D.*4-5, 1922 Address 822 N. Bond St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Gravel Cemetery**Apr 7 1922*

20 UNDERTAKER

ADDRESS

*Chas E Bailey**1821 Jefferson St*

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, c. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Simple. No other  
abnormal condition*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 63201  
1-PLACE OF DEATHCITY OF BALTIMORE: (No. *613 Brant St.* ST. *9* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mariett Ferguson*(a) RESIDENCE. No. *613 Brant St.*  
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. *5* mos. — ) ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

*Female Colored Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Child*6 DATE OF BIRTH (month, day, and year) *Oct-23-1921*7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
*5- — —*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

*None*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Born in Baltimore*

10 NAME OF FATHER

*Jacob Samuel*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *West-Endor Island*12 MAIDEN NAME OF MOTHER *Rebecca Ferguson*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Born in Va*14 Informant (Address) *Mr. Father Jacob Samuel 613 Brant St - March*

APR 6 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 5-1922*17 I HEREBY CERTIFY, That I attended deceased from *March 29th 1922*, to *April 5th 1922*.that I last saw her alive on *April 5th 1922*.and that death occurred, on the date stated above, at *2 p m.*

The CAUSE OF DEATH\* was as follows:

*Broncho-pneumonia*

(duration) yrs. mos. ds.

CONTRIBUTORY *Acute Bronchitis* (Secondary)*Coryza* (duration) *7* yrs. *?* mos. *?* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *no*Was there an autopsy? *no*What test confirmed diagnosis? *Physical Exam*(Signed) *Geo. Hall* M. D., 19 (Address) *426 E 23 St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Laural Cemetery April 5-1922*

20 UNDERTAKER

*Mrs Robert A Elliott Address 1725 Ashland St*

D 63202

HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Provident Hospital* ST. *8* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Grace Jones*(a) RESIDENCE. NO. *2011 Keyser*

(Usual place of abode)

ST.,

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *16* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*Colored*

5 Single, Married, Widowed, or Divorced (write the word)

*Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*James H. Jones*

6 DATE OF BIRTH (month, day, and year)

*1882*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*40*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Domestic*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Domestic*

(c) Name of employer

*None*

9 BIRTHPLACE (city or town) (State or country)

*Do*

10 NAME OF FATHER

*Daniel Wayne*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Do*

12 MAIDEN NAME OF MOTHER

*Not known*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Not known*

14

Informant (Address)

*James H. Jones 2011 Keyser St.*

15

ROBERT R. KRAUTER, Registrar

APR 6 - 1922

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 4* 1922

17

I HEREBY CERTIFY, That I attended deceased from *Apr 3rd* 1922, to *Apr 4th* 1922, that I last saw h. *alive* on *Apr 4th* 1922, and that death occurred, on the date stated above, at *5:30 A* m.

The CAUSE OF DEATH\* was as follows:

*Acute Intestinal Obstruction*CONTRIBUTORY (Secondary) *Shock* (duration) yrs. mos. *5* ds.(duration) yrs. mos. *1* ds.18 Where was disease contracted if not at place of death? *2011 Keyser St*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical*(Signed) *Harry F. Brown*, M. D.Address *1531 Pressman St*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Washington L.C.*

DATE OF BURIAL

*April 7, 1922*

20 UNDERTAKER

*Mrs Robert A. Elliot*

ADDRESS

*1725 Schiand St*

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



D 63203

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 63203

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 E. Lafayette Ave. ST., 41 WARD)

## 2. FULL NAME

William O. Chelton.

## (a) RESIDENCE NO.

1511 E. Lafayette Ave.

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. 8 mos. 16 ds.

## WARD

(If non-resident give city or town and State)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

## 5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofNana Chelton

## 6 DATE OF BIRTH (month, day, and year)

July 20 1880

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.41816

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Steam Fitter

(b) General nature of industry, business, or establishment in which employed (or employer)

Bier Bros.

(c) Name of employer

109-11 Key High Way.9 BIRTHPLACE (city or town)  
(State or country)Maryland

## 10 NAME OF FATHER

George Chelton

## 11 BIRTHPLACE OF FATHER (city or town)

Maryland

## 12 MAIDEN NAME OF MOTHER

Sallie Cullen

## 13 BIRTHPLACE OF MOTHER (city or town)

Maryland

## 14

Informant  
(Address)Nana Chelton (wife)  
1511 E. Lafayette Ave.

## 15

Filed

APR 6 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 5 1922

17 I HEREBY CERTIFY, That I attended deceased from

Jan. 5 1922, to Apr. 5 1922,that I last saw him live on Apr. 4 1922,and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH\* was as follows:

Mitral & Aortic Regurgitation  
(duration) yrs. 5 mos. 5 ds.CONTRIBUTORY  
(Secondary)(duration) yrs. 5 mos. 5 ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed)

J. E. Riverview, M.D.  
Address 1531 E. North Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Cedar Hill4-8 1922

20 UNDERTAKER

ADDRESS

E + B Harber 115 E. West St.

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63204

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

D 63204

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 W. York St - ST. 27 WARD)

## 2-FULL NAME

Harry Green

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE. NO.

103 W. York St -

ST.,

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Colored

## 5 Single, Married, Widowed, or Divorced—(write the word)

Infant5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

Jan 11, 1922

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

225

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Baltimore

## 10 NAME OF FATHER

Paul Green11 BIRTHPLACE OF FATHER (city or town)  
(State or country)N.C.

## 12 MAIDEN NAME OF MOTHER

Myrtle Ward13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)Md

## 14

Informant  
(Address)Myrtle Green  
Mother  
103 W. York St

## 15

APR 6 - 1922

ROBERT R. KROGER,

Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 5, 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

3/15, 1922, to April 3, 1922.that I last saw him alive on April 3, 1922.and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH\* was as follows:

Prematurity.CONTRIBUTORY  
(Secondary)Syphilis, congenital  
(duration) yrs. 2 mos. 25 ds.  
(duration) yrs. 2 mos. 25 ds.

## 18 Where was disease contracted

If not at place of death? yes.Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Laurel StApril 7 1922

## 20 UNDERTAKER

## ADDRESS

L. S. Brown & Son103 W. York St

TION is very important. See instructions on back of certificates.

D 63205

HEALTH DEPARTMENT—CITY OF BALTIMORE

63205

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 95 Kelly Place ST. 13 WARD)

2-FULL NAME

Le Roy Ellsworth Lockner

(a) RESIDENCE. NO. 99 Kelly Place ST. WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

1 yr.

mos.

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec. 12, 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

0

3

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Charles E. Lockner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Addie E. Denton

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Charles E. Lockner 99 Kelly Place

15

APR 6 - 1922

ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 5, 1922

17

I HEREBY CERTIFY. That I attended deceased from

March 28, 1922, to April 5, 1922

that I last saw him alive on April 4, 1922

and that death occurred, on the date stated above, at 3:25 A. M.

The CAUSE OF DEATH\* was as follows:

Acute Pulmonary Edema

(duration) yrs. mos. 2 hrs.

CONTRIBUTORY (Secondary)

Marasmus, Chron. Bronchitis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Machin, M. D.

, 19 (Address) 4119 Falls Road.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Marys Hospital 4/6 1922

20 UNDERTAKER

ADDRESS

Walter Davis 3327

HEALTH DEPARTMENT—CITY OF BALTIMORE **63206**

## CERTIFICATE OF DEATH.

32  
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. **JOHNS HOPKINS HOSPITAL**, **26** WARD)

## 2. FULL NAME

**Bertha Willinger**

## (a) RESIDENCE NO.

**224 S. Chanton St.**

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

**Female**

## 4 COLOR OR RACE

**White**

## 5 Single, Married, Widowed, or Divorced, (write the word)

**single**

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

**Sept 30 - 1918**

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

**3****6****5**

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

**Child**

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

**Baltimore**

## 10 NAME OF FATHER

**George Willinger**

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

**Baltimore**

## 12 MAIDEN NAME OF MOTHER

**Margaret Greenwood**

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

**Baltimore**

## 14

Informant (Address)

**JOHNS HOPKINS HOSPITAL**

## 15

Filed

19

**ROBERT R. KRAUTER,**

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

**April 5 - 1922**

## 17

I HEREBY CERTIFY, That I attended deceased from **April 3<sup>rd</sup>**, 1922, to **April 5<sup>th</sup>**, 1922, that I last saw her alive on **April 5<sup>th</sup>**, 1922,and that death occurred, on the date stated above, at **6:22 a.m.**

The CAUSE OF DEATH\* was as follows:

**Tuberculous meningitis**

(duration)

yrs.

mos.

ds.

## CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

## 18 Where was disease contracted if not at place of death?

**Prob. at home**

Did an operation precede death?

**no** Date of

Was there an autopsy?

**yes**

What test confirmed diagnosis?

**autopsy**

(Signed)

**J. B. Gay**

M. D.

19

(Address)

**Johns Hopkins Hosp.**

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

## DATE OF BURIAL

**Baltimore Cem.****April 7 1922**

## 20 UNDERTAKER

## ADDRESS

**Frank G. Pink****915 N. Gay**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 8 - 1922



**D 63207 HEALTH DEPARTMENT—CITY OF BALTIMORE**

**CERTIFICATE OF DEATH.**

REGISTERED NO. **128**

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. **941 Sarah Ann** ST. **18** WARD)

2-FULL NAME **Augustus Robinson**

(a) RESIDENCE NO. **941 Sarah Ann** ST. **18** WARD.

(Usual place of abode)  
Length of residence in city or town where death occurred **20** yrs. **0** mos. **0** ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX **Male** 4 COLOR OR RACE **col** 5 Single, Married, Widowed, or Divorced (write the word) **married**

5a. If married, widowed, or divorced **since Robinson**  
HUSBAND of (or WIFE of)

6 DATE OF BIRTH (month, day, and year) **2-2-1902**  
7 AGE **20** Years **0** Months **0** Days If LESS than 1 day, **0** hrs. **0** min.

8 OCCUPATION OF DECEASED **Labour 040**

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) **Maryland**  
(State or country)

10 NAME OF FATHER **David Robinson**

11 BIRTHPLACE OF FATHER (city or town) **Maryland**  
(State or country)

12 MAIDEN NAME OF MOTHER **Ann Smith**

13 BIRTHPLACE OF MOTHER (city or town) **Maryland**  
(State or country)

14 Informant **Alice Robinson**  
(Address) **941 Sarah Ann St.**

15 Filed **APR 6 1922** Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH (month, day, and year) **4-5-1922**

17 I HEREBY CERTIFY, That I attended deceased from **Mar 12**, 1922, to **Apr 5**, 1922, that I last saw him alive on **Apr 4**, 1922, and that death occurred, on the date stated above, at **2:30 A.M.**  
The CAUSE OF DEATH\* was as follows: **see certificate**

CONTRIBUTORY (duration) **1** yrs. **0** mos. **0** ds.  
(Secondary) (duration) **1** yrs. **0** mos. **0** ds.

18 Where was disease contracted if not at place of death? **no**

Did an operation precede death? **no** Date of **no**

Was there an autopsy? **no**

What test confirmed diagnosis? **no** M. D.  
(Signed) **Robert H. Kinkaid**  
(Address) **177 E. Lombard St.**

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL **Mt Auburn**

DATE OF BURIAL **Apr 7**

20 UNDERTAKER **Brown, Fred and Charles**

ADDRESS **1194**

tion is very important. See instructions on back of certificates.

D 63208 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

900 63208

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *4* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *St. M. Virginia (Slattery)*(a) RESIDENCE. NO. *Mercy Hospital* ST. *4* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *40* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced\* (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 1, 1835*

7 AGE *86* Years Months *11* Days *4* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Religious*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Tipperary, Ireland*

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ireland*

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*14 Informant *Mercy Hospital Record* (Address)15 *APR 6 - 1922* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 5 1922*

17 I HEREBY CERTIFY, That I attended deceased from *December 1907* to *April 5 1922* that I last saw her alive on *April 5 1922* and that death occurred, on the date stated above, at *11<sup>42</sup>* p.m.

The CAUSE OF DEATH\* was as follows:

*Cardiac decompensation and Bronchial asthma*

CONTRIBUTORY (Secondary)

(duration) *?* yrs. mos. ds.(duration) *24* hrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physical Signs & Symptoms*(Signed) *John J. Brown* M. D.19 (Address) *Mercy Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*St. Agnes Cemetery Mt. Washington* *4-7 1922*20 UNDERTAKER *Henry W. Jenkins & Sons Co* ADDRESS *211 Calhoun**Richards*

TION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63209

## CERTIFICATE OF DEATH.

31 D 63209

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 37 E Hamburg ST., 23 WARD)

## 2-FULL NAME Rosa Mary Butler

(a) RESIDENCE NO. 37 E Hamburg ST.,

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, — hrs.  
or — min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
November 1919 to April 6, 1922.

that I last saw or alive on April 5, 1922.

and that death occurred, on the date stated above, at 5:45 a m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis.

(duration) 3

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

C. E. Burton

M. D.

4/6/1922 (Address) 301 E Cross St.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

APR 6 - 1922

ROBERT B. KLAUTER

Registrar

Burial Permit Clerk.

H. W. Cook

412 W. 11th St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63210

## CERTIFICATE OF DEATH.

REGISTERED NO.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2630 N. Calvert ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Frances Elizabeth O'Brien(a) RESIDENCE. NO. 2630 N. Calvert ST. 17 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>F.</u>	4 COLOR OR RACE <u>W</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
--------------------	-----------------------------	---

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) April 27 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
<u>33</u>	<u>11</u>			

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Telephone Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

Apartment House

(c) Name of employer

M<sup>r</sup>. Kroon9 BIRTHPLACE (city or town)  
(State or country)Baltimore County Md10 NAME OF FATHER Wm O'Brien

11 BIRTHPLACE OF FATHER (city or town)

New York

(State or country)

12 MAIDEN NAME OF MOTHER McCummings

13 BIRTHPLACE OF MOTHER (city or town)

Maryland

(State or country)

## 14

Informant  
(Address)Mary F. O'Brien  
2630 N. Calvert St

## 15

Filed

APR 6 - 1922ROBERT L. ABRAHAM  
Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1922

17 I HEREBY CERTIFY, That I attended deceased from 17 March 1922, to 5 April 1922, that I last saw her alive on 5 April 1922, and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency  
2<sup>nd</sup> corner of Monks  
(duration) yrs. mon. 2 ds.

CONTRIBUTORY  
(Secondary)Burn; 2<sup>nd</sup> & 3<sup>rd</sup> degree  
(duration) yrs. mon. 19 ds.18 Where was disease contracted if not at place of death? 741 W. North AveDid an operation precede death? — Date ofWas there an autopsy? —What test confirmed diagnosis? —(Signed) Wm W. Bryan, M. D.5 Apr 1922 (Address) 749 W North Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

New Cathedral Cemetery April 8 1922

20 UNDERTAKER

William Cook 50 E North Ave



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housewife*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Clothes caught fire  
from stove*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63211

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 63211

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 N Lombard ST.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 1124 N. Lombard St. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 2 1/2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of Fannie Clarke (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 16<sup>th</sup> 1850

7 AGE Years 72 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country)

10 NAME OF FATHER Eli Clarke

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Ant. Clark

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country)

14 Informant Fannie Clarke (Address) 1124 N Lombard

15 Filed APR 6 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1922, to Apr. 5, 1922, that I last saw him alive on Apr. 5, 1922, and that death occurred, on the date stated above, at 11:30 p.m. The CAUSE OF DEATH\* was as follows:

Chronic Bright's Disease  
Interstitial Nephritis  
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urin. Examination

(Signed) Thas. Porten, M. D.

(Address) 888 N Lombard St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Harperbury Va April 8 19

20 UNDERTAKER ADDRESS 22

John J. Fields 1200 N Lombard

D 63212

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

100-001  
D 63212

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 23 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Heintz (Heinz)(a) RESIDENCE, No. Unknown 1020 S. Sharp ST.      WARD.       
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Unknown5a If married, widowed, or divorced HUSBAND of Jacob Heinz (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 1854 Oct 207 AGE Years 70 Months -5 Days 24 If LESS than 1 day, hrs.      or min.     

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework(b) General nature of industry, business, or establishment in which employed (or employer) god(c) Name of employer     9 BIRTHPLACE (city or town) Baltimore  
(State or country) Maryland10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown  
(State or country) Germany12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country) Germany14 Informant Hospital Records,  
(Address) Municipal Hospital.15 Filed APR 6 - 1922 Registrar GLJ

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 19 2217 I HEREBY CERTIFY, That I attended deceased from March 9, 19 22, to April 3, 19 22.that I last saw her alive on April 3, 19 22.and that death occurred, on the date stated above, at 7:40 P.M.

The CAUSE OF DEATH\* was as follows:

Arturosebronis(duration) 10 yrs. mos. ds.CONTRIBUTORY Broncho pneumonia  
(Secondary) (duration) 2 yrs. mos. ds.18 Where was disease contracted  
if not at place of death?Did an operation precede death? no Date of     Was there an autopsy? noWhat test confirmed diagnosis?       
(Signed) Clyde McNeill, M. D.4/4/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL April 7 192220 UNDERTAKER Chas. Schlorman & Son ADDRESS 037

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

# D 63213 HEALTH DEPARTMENT—CITY OF BALTIMORE 63213

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

City of BALTIMORE: (No. 212 W. Dickman St. St. 23 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### 2-FULL NAME

Anna E. Dickman.

55

(Residence in Baltimore: No. 212 W. Dickman St. St.; yrs. 55 mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, September, 13th, 1850. 1. (Month) (Day) (Year)

7-AGE, 71 yrs. 6 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Germany.

10-NAME OF FATHER, Herman Wagner.

11-BIRTHPLACE OF FATHER, (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country), Germany.

14-IF THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick Schweigert. (son)

(Address) 6th St. Brooklyn.

15

APR 6 - 1922

Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 5th, 1922. 192. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) And that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Fracture of the left thigh. Accidental fall on the floor. Feb. 10th, 1922. General debility.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D. (Coroner) April 5th, 1922 (Address) 1017 E. Charles St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Balto Cemetery April 8, 1922

20-UNDERTAKER, ADDRESS 1034

O. Schlomau-Won

State Cause of Death in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

*J. Rittenhouse*

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63214

## CERTIFICATE OF DEATH.

168

D 63214

PLACE OF DEATH

CITY OF BALTIMORE (No. *2429 Guilford Ave*)

2-FULL NAME

(Residence in Baltimore: No. *2427 Guilford Ave*)

WARD

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.) *41 11 16*

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*Female*

4-COLOR OR RACE,

*white*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH,

*April 19, 1880*  
(Month) (Day) (Year)

7-AGE,

*41 yrs. 11 mos. 16 ds.*

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *house duties*  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

*Balto. Md.*

10-NAME OF FATHER,

*James H. Swift*

11-BIRTHPLACE OF FATHER (State or Country),

*Harford Co.*

12-MAIDEN NAME OF MOTHER

*May L. Quinlan*

13-BIRTHPLACE OF MOTHER (State or Country),

*Balto. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Mary M. Swift*

(Address)

*2429 Guilford Ave*

15-

Filed APR 26 - 1922

Registrar, *John Ormitchell*

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

*April 5, 1922*  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*

thereon and from the evidence obtained by said *inquest*

and that said deceased came to death

on the date stated above.

The CAUSE OF DEATH was as follows:

*Shuntaken*  
*Subacute*  
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Signed) *J. Rittenhouse* M. D.

(Coroner) *J. Rittenhouse* Address *713 E. R. Road*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,

*Hudson Park*

DATE OF BURIAL,

*April 7, 1922*

20-UNDERTAKER

*John Ormitchell 1301 W. Fayette*

D 63215

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

129 D 63215

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1917 Guilford Ave.

ST. 12 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Eva Prettyman

(a) RESIDENCE. No. 1917 Guilford Ave.  
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 4 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced

DECEASED  
(or) WIFE of

Albert B. Prettyman

6 DATE OF BIRTH (month, day, and year) Nov. 20, 1951

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
67 4 16

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

house work 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Sussex Co.  
(State or country) Delaware

10 NAME OF FATHER P. E. Atkins

11 BIRTHPLACE OF FATHER (city or town)  
(State or country) Delaware

12 MAIDEN NAME OF MOTHER Sallie A. Burton

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country) Delaware14 Informant Albert B. Prettyman  
(Address) 1917 Guilford Ave.

15 Filed APR 6 - 1922 19 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5, 1922 19

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1922, to April 5, 1922, that I last saw her alive on April 4, 1922, and that death occurred, on the date stated above, at 5:45 AM m. The CAUSE OF DEATH\* was as follows:

Chronic Intestinal neplritis

CONTRIBUTORY (Secondary) (duration) 4 yrs. mos. ds. Chronic

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Smith M. D. 45, 1922 Address) 438 Maryland Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Druid Ridge Cemetery

5-7-22 19

20 UNDERTAKER

ADDRESS

H. E. Hughes

424 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63216

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

46 D 63216

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 4 Durham ST., 8 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 9 mos. 4 ds.

ST.,

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 4 yrs. 9 mos. 4 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 ~~Single~~, Married, Widowed, or Divorced. (write the word)5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
t day, .... hrs.  
or .... min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from  
July 18, 1918, to Apr 4, 1922,  
that I last saw him alive on Apr 4, 1922

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)18 Where was disease contracted  
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63217

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 1/2 W. Hazwood Ave. ST. 27 WARD)

## 2-FULL NAME

Unnamed (Infant) Deminger

(a) RESIDENCE NO. 103 1/2 Hazwood Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 6 - 1922

7 AGE Years Months Days If LESS than 1 day, hrs. or 5 min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

10 NAME OF FATHER Alfred Deminger

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md (State or country)

12 MAIDEN NAME OF MOTHER Mary Walter

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md (State or country)

14 Informant Mrs Deminger (Address) 16 1/2 W. Hazwood Ave

15 Robert F. Harrison, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5 1922

17 I HEREBY CERTIFY, That I attended deceased from on Apr 5, 1922, to Apr 5, 1922,

that I last saw him alive on Apr 5, 1922, and that death occurred, on the date stated above, at 2:35 P. M.

The CAUSE OF DEATH\* was as follows:

Premature (about 4 months)

(duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank E. Hilliard, M. D.

(Address) 2636 Kato Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

Deminger

DATE OF BURIAL

ADDRESS

APR 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

6-1922



Exact statement of OCCUPA-  
TION is very important. See instructions on back of certificates.

Spec. 1-10-21-M&T-1500 Bks.

2-D 63218

HEALTH DEPARTMENT—CITY OF BALTIMORE D 63218

CERTIFICATE OF DEATH.

100-001

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Frank Schuyler

(a) RESIDENCE NO. 644 W Fayette St ST. Baltimore WARD

(Usual place of abode) (If non-resident give city or town and State)  
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

6 If married, widowed, or divorced Husband of Charles W. Schuyler, parent.

6 DATE OF BIRTH (month, day, and year) Aug 24, 1921

7 AGE 7 Years 110 Months 11 Days 11 LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md. (State or country)

10 NAME OF FATHER Charles Schuyler

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Mrs. Corbett

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Robert F. Harrison, Registrar

6-1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1922

17 I HEREBY CERTIFY, That I attended deceased from 1922 to April 9, 1922

that I last saw him alive on April 9, 1922 and that death occurred, on the date stated above, at 4:30 A. M.

The CAUSE OF DEATH\* was as follows:

Pneumonia (bronchopneumonia)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted 644 W Fayette St if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) T.B. Gay M. D.

19 (Address) Johns Hopkins Hosp

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
JOHNS HOPKINS HOSPITAL

DATE OF BURIAL APR 12 1922

20 UNDERTAKER Commissioner Health.

Commissioner Health.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assoc.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*No infection prior.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63219

## CERTIFICATE OF DEATH.

D 63219

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 Municipal Tuberculosis Hospital) WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Simms(a) RESIDENCE. No. 510 Montgomery st.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

MaleColoredSingle

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1890

7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

32

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town) (State or country)

Maryland10 NAME OF FATHER Elias Simms

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland12 MAIDEN NAME OF MOTHER Lizzie Doie

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant (Address)

Hospital RecordsM.T.H.

15

Filed

Robert P. Harrison,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 4, 1922, to April 3, 1922.that I last saw him alive on April 3, 1922.and that death occurred, on the date stated above, at 8.50 p. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

Pneumothorax

(duration) yrs. 2 mos. ds.

18 Where was disease contracted

If not at place of death?

UnknownDid an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray(Signed) Francis L. Dabaghiacca M. D.4-4-22 (Address) Municipal Tbc. Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

UNIVERSITY OF MARYLAND.

20 UNDERTAKER

ADDRESS

Comptroller Health

APR 5 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R6-1922

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63220

## CERTIFICATE OF DEATH.

D 63220

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3716 Gough ST., 76 WARD)

REGISTERED NO. X 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

### 2-FULL NAME

Annade M. Cleaver

(a) RESIDENCE NO. 3716 Gough ST., Westminster Md WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

1922

19 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

31 Mar, 1922, to 5 Apr, 1922,

that I last saw her alive on 5 Apr, 1922,

and that death occurred, on the date stated above, at 11:30 m.

The CAUSE OF DEATH\* was as follows:

Subtle Melancholia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. signs in case

(Signed) W. M. M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DEATH on back of certificates. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63221

D 63221

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *405 N. Euter St.* ST., *5* WARD)

2-FULL NAME

(a) RESIDENCE NO. *405 N. Euter St.* ST.,

(Usual place of abode)

Length of residence in city or town where death occurred *41* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *unknown 1 861*

7 AGE *61* Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Germany.* (State or country)

10 NAME OF FATHER *Henry Peltz.*

11 BIRTHPLACE OF FATHER (city or town) *Germany.* (State or country)

12 MAIDEN NAME OF MOTHER *Frederick Thiel*

13 BIRTHPLACE OF MOTHER (city or town) *Germany.* (State or country)

14 Informant *William F. Peltz.* (Address) *1774 Homestead St.*

15 *Robert F. Harrison,* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 6 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Feb 1 1922* to *Apr 6 1922*, that I last saw him alive on *Apr 5 1922*, and that death occurred, on the date stated above, at *1:45 a. m.* The CAUSE OF DEATH\* was as follows:

*Carcinoma of Stomach*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? *Aug. 8 Di. Stefano* (Signed) *Apr 6 1922* (Address) *407 N. Euter St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*St. Matthews Cem*

*Apr 8 1922*

20 UNDERTAKER

ADDRESS *2008 William*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Hk.

D 63222

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63222

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1007 Bush ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO. 1007 Bush

(Usual place of abode)

ST.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

File

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb 10, 1922 to April 6, 1922, that I last saw her alive on April 5, 1922, and that death occurred, on the date stated above, at 9 a. m. The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Mary F. Voeglein, M. D.  
April 6, 1922 (Address) 1028 Valley St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

DATE OF BURIAL

Apr 10 1922

ADDRESS

2008 Chesa

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. -1-10-21-MAT-1500 Hks.

D 63223

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63223

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2042 E Fayette St. WARD 6)

2-FULL NAME

Frank J. Saffer

(a) RESIDENCE NO.

2042 E Fayette St. WARD 6

(Usual place of abode)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed or divorced

HUSBAND of

Margaret Saffer

6 DATE OF BIRTH (month, day, and year)

Aug 1892

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

29 7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Frank Saffer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Mary Koenig

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant

(Address)

Margaret Saffer 2042 E Fayette St.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 - 4 1922

17

I HEREBY CERTIFY, That I attended deceased from

4 - 2 1922, to 4 - 4 1922.

that I last saw him live on 4 - 4 1922.

and that death occurred, on the date stated above, at 6:20 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Chenya

(duration) yrs. mos. ds.

18 Where was disease contracted

not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elijah J. Russell M. D.

19 (Address) 156 N. Milton Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE

DATE OF BURIAL

NOVA

Holy Redeemer Cem 4-7-22

20 UNDERTAKER

J. G. Moran

ADDRESS 300 E. Balto.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63224

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1931 White

ST. 70 WARD)

2-FULL NAME

Harold M. Middleton

(a) RESIDENCE. No. 1931 White

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 3 mos.

ds. How long in U. S., if of foreign birth?

yrs. 7 mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M.

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

APR 7 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5 1922

17

HEREBY CERTIFY, That I attended deceased from

Apr 1 1922, to Apr 4 1922

that I last saw him alive on Apr 4 1922

and that death occurred, on the date stated above, at 7 9 m.

The CAUSE OF DEATH\* was as follows:

Acute Enteritis

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Apr 6 22

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS 1303



CAUSE OF DEATH IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

63225

HEALTH DEPARTMENT—CITY OF BALTIMORE

63225

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Pronounced dead at

Registered No. C.....

City of BALTIMORE: (No. Franklin Square, Hampton 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Brown

(Residence in Baltimore: No. 1038 Stricker St. 5th yrs. .... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH,

Unknown 1 (Month) (Day) (Year)

7-AGE,

34 yrs. .... mos. .... ds.

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer).

private family

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

J. S. Hall

11-BIRTHPLACE OF FATHER, (State or Country),

Maryland

12-MAIDEN NAME OF MOTHER,

Fannie Jones

13-BIRTHPLACE OF MOTHER, (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. C. Hall

(Address)

1515 Calhoun St

15-

APR 7 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 5, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Angina Pectoris

CONTRIBUTORY (Secondary)

(Duration) yrs. 3 mos. .... ds.

(Signed) James M. Gordon

(Duration) yrs. .... mos. .... ds.

(Coroner.)

1922 (Address) 700 E. Chase St

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

Wm. A. Brown April 9, 1922

20-UNDERTAKER,

ADDRESS 143

James H. Brown Eastman St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63226

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2139 Stanford ans* ST.: *8* WARD)

## 2-FULL NAME

*Charles W. Biddison.*

## (a) RESIDENCE. NO.

*2139 Stanford ans*

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *5* yrs. mos. ds. How long in U. S., if of foreign birth? *1* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 Single, Married, Widowed, or Divorced (write the word)

*Married*

5a If married, widowed, or divorced

HUSBAND of  
(or WIFE)*Frances A Biddison*6 DATE OF BIRTH (month, day, and year) *Oct 2, 1849*

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*72**6**3*

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Pensioner 073*

(b) General nature of industry, business, or establishment in which employed (or employer)

*P. R. R. Co.*

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Baltimore Md.*

10 NAME OF FATHER

*William Biddison*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Baltimore Md.*

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Baltimore*

14

Informant  
(Address)*Frances A Biddison  
2139 Stanford ans*

15

*APR 7 - 1922**ROBERT R. MAITER*  
Registrar

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 5 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*May 7 1921*, to *Apr 5 1922*,that I last saw him alive on *Apr 4 1922*,and that death occurred, on the date stated above, at *12 40* m.

The CAUSE OF DEATH\* was as follows:

*Arterio - Sclerosis*(duration) *1* yrs. mos. ds.CONTRIBUTORY  
(Secondary)*Cerebral Hemorrhage*

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Walter W White Jr*, M. D.#*6*, 1922 (Address) *2800 St Paul st*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Orem Cemetery Md**April 7 1922*

20 UNDERTAKER

ADDRESS

*Lilly & Ziehl**403  
S. Wolfe*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

63227  
Spec.-1-10-21-M&T 1500 Rts.

D 63227

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

✓63227  
D 63227

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hosp. Women of Md ST. 25 WARD)

2-FULL NAME Mrs. Estella E. Warrington

(a) RESIDENCE No. Curtis Bay, Md ST. WARD

(Usual place of abode)  
Length of residence in city or town where death occurred 43 yrs. 7 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced  
HUSBAND of S. M. Warrington  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 19, 1878

7 AGE Years 43 Months 7 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md  
(State or country)

10 NAME OF FATHER Joseph Deane

11 BIRTHPLACE OF FATHER (city or town) Balto (??)  
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Burton

13 BIRTHPLACE OF MOTHER (city or town) Balto  
(State or country)

14 Informant Samuel M. Warrington  
(Address) Curtis Bay

15 APR 7 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar. 15, 1922 to Apr. 5, 1922

that I last saw him alive on Apr 5, 1922

and that death occurred, on the date stated above, at 1.47 A m.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia & cardiac failure.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? N. W. of Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Leslie E. Myatt M. D.

Address N. W. of Md

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Landon Park Cemetery

April 8 1922

20 UNDERTAKER

ADDRESS

Joseph B. Cook

1003 1/2 Balto

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63228

D 63228

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2075 Ridgewood Ave. ST. 15 WARD)2-FULL NAME Margaret Dahlweiner(a) RESIDENCE NO. 2075 Ridgewood Ave. ST. 15 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 3 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of John C. Dahlweiner6 DATE OF BIRTH (month, day, and year) Dec. 10 18607 AGE Years Months Days If LESS than 1 day, hrs. or min. 61 3 26

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER John Emerick11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Barlotta Pickles13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany14 Informant (Address) John C. Dahlweiner  
2075 Ridgewood Ave.15 APR 7 - 1922 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 192217 I HEREBY CERTIFY, That I attended deceased from March 25 1922 to April 5 1922 that I last saw him alive on April 5 1922 and that death occurred, on the date stated above, at 7:25 P. m. The CAUSE OF DEATH\* was as follows:Carcinoma  
of the  
stomach  
(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. H. C. C. C. M. D.4/6/22 (Address) 2757 W. Monaca

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Joseph B. Cook 1003 N. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



D 63229 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63229

1-PLACE OF DEATH *South Balt. General Hospital*

REGISTERED NO.

CITY OF BALTIMORE: (No. *1213 Light St.* ST. *70* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mr. Clarence A. Jones*(a) RESIDENCE, NO. *1802 Kenner Ave* ST. WARD.(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred *70* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced  
HUSBAND of *Miss M. Jones*6 DATE OF BIRTH (month, day, and year) *March 13-1873*7 AGE *49* Years Months Days *73* If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Barber*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Howard Co Md.*  
(State or country)10 NAME OF FATHER *Arthur M. Jones*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)12 MAIDEN NAME OF MOTHER *Janella Murray*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)14 Informant *Howard C. Jones*  
(Address) *Haltorpe Rd.*15 Filed *APR 7-1922* 19 *EX* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 5 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*March 20, 1922, to April 5, 1922,*that I last saw him alive on *April 5, 1922,*and that death occurred, on the date stated above, at *9:12 P.M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Nephritis*(duration) *(?)* yrs. mos. ds.CONTRIBUTORY  
(Secondary)*(?)* (duration) yrs. mos. ds.18 Where was disease contracted?  
If not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Carl F. Benson* M. D.19 (Address) *South Balt. General Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Older Co.* *Apr 8 1922*

20 UNDERTAKER

*Joseph B. Cook* ADDRESS *1031 E. Baltimore*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63230

## CERTIFICATE OF DEATH.

D 63230

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Maryland General Hospital

ST.: 15

WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mary C. Phipps

## (a) RESIDENCE. NO.

1265 Dukeland

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Married

## 5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Wm. C. Phipps

## 6 DATE OF BIRTH (month, day, and year)

Oct 4, 1888

## 7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

33

6

1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

Baltimore

(State or country)

Md.

## 10 NAME OF FATHER

Frank X. Cebrowski

## 11 BIRTHPLACE OF FATHER (city or town)

Baltimore

(State or country)

Md.

## 12 MAIDEN NAME OF MOTHER

Mauda Eglins

## 13 BIRTHPLACE OF MOTHER (city or town)

Baltimore

(State or country)

Md.

## 14

Informant  
(Address)William A. Phipps  
1705 Dukeland Ave.

## 15

Filed

APR 7 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

April 5 1922

## 17

I HEREBY CERTIFY, That I attended deceased from

April 3rd 1922 to April 5 1922

that I last saw her alive on April 5 1922

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH\* was as follows:

Bilateral Ovarian

cancer

(duration) yrs. ? mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No. Date of April 4, 1922

Was there an autopsy? No.

What test confirmed diagnosis? Operation &amp; clinical findings

(Signed)

Geo. R. W. W. W.

M. D.

19 (Address)

Md. General Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Lorraine Cemetery

Apr 8 1922

## 20 UNDERTAKER

## ADDRESS

Joseph B. Cook

1003 N. E. St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Probably due to  
gonococcus  
infection. Operation  
for pyosalpinx*

D 63231

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 Rumbauton ST., WARD)

2-FULL NAME

(a) RESIDENCE NO. 628 Rumbauton ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX m 4 COLOR OR RACE wh 5 Single, Married, Widowed, or Divorced, (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-28-22

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St. Agnes Hosp. Baltimore, Md. (State or country)

10 NAME OF FATHER Andrew Wright

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret Bates

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Andrew Wright

(Address) 628 Rumbauton St.

15 APR 7 - 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-5-22 19

17 I HEREBY CERTIFY, That I attended deceased from

3-28-22, 19 to 4-5-22, 19

that I last saw him alive on 4-5-22, 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage at birth followed by Spasms Hemiplegia - Hemiparesis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) W.C. Caldwell M. D.

, 19 (Address) St. Agnes Hosp.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Agnes Cathedral

April 7, 1922

20 UNDERTAKER

ADDRESS

C.A. Weddfield Jr.

501 E 22





# Remarks

Operation about year ago for suspected carcinoma cervix uteri. Microscopical examination of scrapings showed carcinoma cells.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

*lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

*Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.*

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63233

## CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

University Hospital

CITY OF BALTIMORE (No.

Lombard &amp; Jones

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs. Nora J. Scott

(a) RESIDENCE. NO.

Savage, Md.

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1868

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

54

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Va.

10 NAME OF FATHER

James Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va.

12 MAIDEN NAME OF MOTHER

Virginia Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va.

14

Informant (Address)

Hospital Record

15

APR 7 - 1922

ROBERT R. KRAUTER, Registrar  
Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/6

1922

17

I HEREBY CERTIFY, That I attended deceased from

3/31

1922, to

4/6

1922

that I last saw him alive on

4/6/

1922

and that death occurred, on the date stated above, at

11 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis (due to Hypothyroidism).

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Broncho Pneumonia

(Bilateral) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical test

(Signed)

Leon M. M. D.

, 19 (Address)

University Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Savage Md.

DATE OF BURIAL

4-7 1922

20 UNDERTAKER

E. B. Hasker 115 E. 2nd St.

D 63234

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63234

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Josephs Hosp* ST.; *1* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *818 Superior Ave* St.; *unknown* yrs., *unknown* mos., *unknown* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

## 6-DATE OF BIRTH.

*1857*  
(Month) (Day) (Year)

## 7-AGE.

*65* yrs. *2* mos. *25* ds.

If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Laborer*  
*040*

## 9-BIRTHPLACE, (State or Country).

*Poland*

## 10-NAME OF FATHER.

*Not Known*

## 11-BIRTHPLACE OF FATHER (State or Country).

*Poland*

## 12-MAIDEN NAME OF MOTHER

*Not Known*

## 13-BIRTHPLACE OF MOTHER (State or Country).

*Poland*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Michael Ezdebski*(Address) *818 Superior Ave*

15-APR 7-1922

ROBERT R. KRAUTER,

Filed....., 191.....

Burial Permit *040*

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

*April 5*, 19*22*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*April 1* 19*22* to *April 5* 19*22*that I saw him alive on *April 5* 19*22*and that death occurred, on the date stated above, at *9 p* m.

The CAUSE OF DEATH\* was as follows:

*Myocardial Infarction*

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) *Hypertension*

(Duration) .... yrs. .... mos. .... ds.

(Signed) *S. W. Krauter* M. D......, 191... (Address) *St. Josephs Hosp.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

## DATE OF BURIAL.

*St. Stanislaus Cem.**April 5*, 19*22*

## 20-UNDERTAKER

## ADDRESS

*Stephen Ezdebski**100 S. Howard*

CRUCIAL OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EARLY STATEMENT OF OCCUPATION IS VERY important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63235

D 63235

## CERTIFICATE OF DEATH.

100-001

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 68 Darby St. ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Beck(a) RESIDENCE NO. 68 Darby St. ST. 13 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 mos. 21 ds. How long in U. S., if of foreign birth? 1 yrs. 11 mos. 21 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Infant

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 16, 1920

7 AGE Years 1 Months 11 Days 21 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto city (State or country) Maryland10 NAME OF FATHER Frederick A Beck11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)12 MAIDEN NAME OF MOTHER Jeannette T Hood13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.14 Informant Frederick A Beck (Address) 68 Darby St15 APR 22 1922 ROBERT R. KRAUTER Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1922

17 I HEREBY CERTIFY, That I attended deceased from

was 26th, 1922, to April 6th, 1922.that I last saw him alive on April 5th, 1922.and that death occurred, on the date stated above, at 7:25 A m.

The CAUSE OF DEATH\* was as follows:

Pneumo-Pneumonia(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ✓Was there an autopsy? NoWhat test confirmed diagnosis? Physician's findings(Signed) B. G. Reeves M. D.Address 7527 Union Ave.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Marys Hampden 4/8 19 22

20 UNDERTAKER ADDRESS

3307 Pikes

TION is very important. See instructions on back of certificates.

D 63236

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

46 D 63236

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 Chatham ST.: 12th WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Mary Wilson

## (a) RESIDENCE. No.

1211 Chatham ST.: 12th WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

Col

## 5 Single, Married, Widowed, or Divorced (write the word)

married

## 5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Charles H. Wilson

## 6 DATE OF BIRTH (month, day, and year)

Nov-1894

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

38

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

House

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

Md.

## 10 NAME OF FATHER

Jas. Coleman

## 11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

## 12 MAIDEN NAME OF MOTHER

unknown

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

## 14

Informant (Address)

Chas H Wilson 1211 Chatham St

## 15

APR 7 - 1922 ROBERT R. KRAUTER

Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/5 1922

17

I HEREBY CERTIFY That I attended deceased from 1/8 1922 to 4/5 1922 that I last saw him alive on 4/5 1922 and that death occurred, on the date stated above, at 8.40 a.m.

The CAUSE OF DEATH\* was as follows:

Carcinoma (uteri)  
about 3 (history)

CONTRIBUTORY (Secondary)

Undetermined18 Where was disease contracted if not at place of death? noDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? clinical(Signed) Chas H Wilson M. D.4/5/22 (Address) 908 S. Howard St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lane CemeteryApril 8 1922

20 UNDERTAKER

George F. Ruck

ADDRESS

1235 Howard St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63237

## CERTIFICATE OF DEATH.

90 D 63237

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 525 W. 1<sup>st</sup> Barre ST.: 22 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Margaret Bergmann

## (a) RESIDENCE. NO.

525 W. 1<sup>st</sup> Barre

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? 65 yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of John C. Bergmann6 DATE OF BIRTH (month, day, and year) May 23<sup>rd</sup> 18407 AGE Years 81 Months 10 Days 13 If LESS than 1 day, — hrs. or — min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

## 10 NAME OF FATHER

Herman Gohlinghorst11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

## 12 MAIDEN NAME OF MOTHER

Mary Kappelman13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

## 14

Informant Elizabeth Bergmann  
(Address) 525 W. 1<sup>st</sup> Barre St.

## 15

APR 7 - 1922 ROBERT A. KRAUTER Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5<sup>th</sup> 192217 I HEREBY CERTIFY, That I attended deceased from Jan, 1901, 1922, to April 5<sup>th</sup> 1922, that I last saw her alive on April 5<sup>th</sup> 1922, and that death occurred, on the date stated above, at 2:20 p.m.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Disease  
Heart(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Valvular Lesions(Signed) A. G. Carrick, M. D.19 (Address) 412 N. Calhoun

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery April 8<sup>th</sup> 1922

20 UNDERTAKER

ADDRESS

Mr. & Mrs. John H. Leffel & Son 801 N. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63238

## CERTIFICATE OF DEATH.

X 112 D 63238

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2053 Division St.* WARD *14*)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

*Maggie Thomas*

## (a) RESIDENCE. No.

(Usual place of abode)

*731 Junilla Pittsburg Pa*

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *30* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Wm Thomas*6 DATE OF BIRTH (month, day, and year) *Apr - 6 - 1867*7 AGE *53* Years Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Home keeping*

(c) Name of employer

*Self*

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md*

## 10 NAME OF FATHER

*General Blakey*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Key*

## 12 MAIDEN NAME OF MOTHER

*(Ellen Woods)*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Key*

## 14

Informant (Address)

*Wm Thomas 731 Junilla St Pittsburg Pa*

## 15

APR 7 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 6 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Mar 16 1922* to *Apr 5 1922*that I last saw her alive on *Apr 5 1922*and that death occurred, on the date stated above, at *7 a m.*

The CAUSE OF DEATH\* was as follows:

*Malnutrition, anemia & toxemia*

CONTRIBUTORY (Secondary)

*Gastric ulcer with perforation* (duration) yrs. *3* mos. ds. mor. *20* ds.18 Where was disease contracted if not at place of death? *cannot say*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Lactacid test*(Signed) *Edw Short* M. D.16, 19 (Address) *1812 Druid Hill av*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Pittsburg Pa*

## 20 UNDERTAKER

*Samuel Weensley*

DATE OF BURIAL

*Apr 8 1922*ADDRESS *578 St Biddle St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Nonmalignant*

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 63239

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63239

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. *2801 O'Donnell* St. *1* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mario Anne Jaworski & Lester Davis*

(Residence in Baltimore: No. *2801 O'Donnell* St.; yrs. .... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, *Single* (Write the word.)

6-DATE OF BIRTH, *Mar 21* *1922* (Month) (Day) (Year)

7-AGE, *1* *mo.* *1* *ds.* *5* *hrs.* or *min.* If LESS than 1 day, yrs. .... mos. .... ds. .... hrs. .... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *None* (b) General nature of industry, business, or establishment in which employed (or employer), *None*

9-BIRTHPLACE, (State or Country), *Balt city*

10-NAME OF FATHER, *Lester Davis*

11-BIRTHPLACE OF FATHER, (State or Country), *Balt city*

12-MAIDEN NAME OF MOTHER, *Marianne Jaworski*

13-BIRTHPLACE OF MOTHER, (State or Country), *Balt city*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Melcho Jaworski*

(Address), *2801 O'Donnell*

15- *Robert J. ...*

Filed *1922* Registrar.

*1922* Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *March* *21* *1922* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Autopsy* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Autopsy* and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows: *fracture lower jaw 3 lbs. Hemorrhage into brain. Inpatient's sudden* (Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) (Duration) .... yrs. .... mos. .... ds.

(Signed) *James M. Kemmer* M. D. (Coroner.) *47* *1922* (Address) *700 E. Charles St*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, .... yrs. .... mos. .... ds. In the State, .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

*St Stanislaus Cem* *April 7* *1922*

20-UNDERTAKER, ADDRESS

*Stephen J. Polkowski* *1000 Shamrock*

D 63240

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63240

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2105-N-Calvert-St.

ST.: 12 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Griffin Hebb.

(a) RESIDENCE. No 2105-N-Calvert-St.

ST., 12 WARD. (Resident)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs ? mos. ? ds. How long in U. S., if of foreign birth? 74 yrs 6 mos 6 ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Widowed

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Bettie Thompson Hebb

6 DATE OF BIRTH (month, day, and year) October-3-1847

7 AGE

Years

Months

Days

If LESS than  
1 day. hrs.  
or min.

74

6

6

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

None

9 BIRTHPLACE (city or town)  
(State or country) Great Mills,  
St. Mary's Co., Md.

10 NAME OF FATHER Thomas Hebb

11 BIRTHPLACE OF FATHER (city or town) Great Mills

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER Eliza Clark

13 BIRTHPLACE OF MOTHER (city or town) Great Mills  
(State or country) Maryland14 Informant Miss Mary E. Hebb, (daughter)  
(Address) 2105-N-Calvert-St., City.

15 Filed

APR 10 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 24, 1922, to April 6, 1922.

that I last saw him alive on April 6, 1922.

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(duration) yrs. 14 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Henry M. Bayley, M. D.  
2905 N. Calvert St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

LOUDON PARK CEMETERY

APRIL 9-22

20 UNDERTAKER

STEWART & MOWEN COMPANY  
(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(In Automobile) 36th St. & Chestnut Ave.  
D 63241 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63241

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. 36. Chestnut St. 731 WARD)

FULL NAME Jesse L. Behler

(Residence in Baltimore: No. Key Ave. near Greenspring Ave. St. 44, — mos. — da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX

Male

COLOR OR RACE

White

SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)

Married

DATE OF BIRTH

Sept. 17, 1878 (Month) (Day) (Year)

AGE

43 yrs. 6 mos. 19 ds.

IF LESS than 1 day, ... hrs. or ... min.

OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Contracting Painter

BIRTHPLACE

(State or Country)

Balto. Co. Md.

NAME OF FATHER

Frank H. Behler

BIRTHPLACE OF FATHER

(State or Country)

Germany

MAIDEN NAME OF MOTHER

Sarah Lutch

BIRTHPLACE OF MOTHER

(State or Country)

Balto. Co. Md.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Elsie M. Behler

(Address)

Key Ave.

15-

Robert P. Harrison,

IDL

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

DATE OF DEATH

April 5, 1922 (Month) (Day) (Year)

17-

I HEREBY CERTIFY, that I took charge of the

remains described above, held an inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by and from the

and that said deceased came to death (Topsy or inquiry) on the day stated above.

The CAUSE OF DEATH was as follows:

Heart disease

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signature) M. D.

(Address) 7632 Rolan

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lynd Ridge

April 8, 1922

UNDERTAKER

ADDRESS

Norace H. Burge

3631 Falls Rd.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION, if any, important. See instructions on back of certificate.

9-7-1922



Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63242

## CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *2100 Hospital St.* WARD)

2-FULL NAME

(Residence in Baltimore: No. *Sweden*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE

*White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)

*Single*

6-DATE OF BIRTH,

(Month) (Day) (Year)

7-AGE,

*31*

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

*Sailor Pacific S.S. Co.*

9-BIRTHPLACE, (State or Country),

*Sweden*

10-NAME OF FATHER,

*Anttman*

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

*Anttman*

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

*Robert P. Harrison,*

191

Registrar.

27-1922

Burial Permit Clerk.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

*April 3, 1922*

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Pneumonia left lung side of heart in factor*

CONTRIBUTORY (Secondary)

(Signed) *J. J. McLaughlin* M. D.

(Address) *422 W. 4th St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs... mos... ds. In the State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Trinity Cemetery 4-8-22*

20-UNDERTAKER

ADDRESS

*J. J. Moran 2 Baiton*

*Traumatism fall. Broken back not  
drowned.*

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges,*

*peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

*Abortion*, *Hæmorrhage*, *Meningitis*, *Phlebitis*,  
*Cellulitis*, *Gangrene*, *Miscarriage*, *Pyæmia*,  
*Childbirth*, *Gastritis*, *Necrosis*, *Septicæmia*,  
*Convulsions*, *Erysipelas*, *Peritonitis*, *Tetanus*.

The following must be referred to a Coroner:

*Deaths due to accident* (if criminal negligence possibly involved); *Suicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.

D 63243

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63243

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: NO. 1616 W. Cullough St. 14

WARD)

## 2. FULL NAME

John H. Murphy Sr.

(a) RESIDENCE NO. 1616 W. Cullough St.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 81 yrs.

mos.

ds.

How long in U. S. If of foreign birth? yrs. mos. ds.

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 26 - 1891

7 AGE 81 Years 3 Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Publisher

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Md. (State or country)

10 NAME OF FATHER Benj. Murphy

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Susan Coby

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

PARENTS

14 Informant (Address) George Murphy

15

Filed

Robert F. Harrison,

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/5/1922

17 I HEREBY CERTIFY, That I attended deceased from Mar. 15, 1922, to Apr. 5, 1922,

that I last saw him alive on Apr. 5, 1922,

and that death occurred, on the date stated above, at 2:05 P. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Oedema

(duration) yrs. mos. ds. 3

CONTRIBUTORY Diffuse arterio-sclerotic (Secondary) (duration) yrs. mos. ds. unknown

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Thompson, M. D.

19 (Address) 1019 Duval Hill

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt. Auburn Cem. April 19, 1922

ADDRESS

20 UNDERTAKER

George H. Holland, 1631 Duval Hill

Baltimore Health Department

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assoc.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

*Not apoplectic.*  
*No hemorrhages.*  
*Primary arteriosclerosis.*



D 63244

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.,

WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

ST.,

WARD

Length of residence in city or town where death occurred

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer.

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1920, to April 6, 1922, that I last saw him live on April 6, 1922, and that death occurred, on the date stated above, at 11:54 a.m.

The CAUSE OF DEATH\* was as follows:

Broncho-Pneumonia (Terminal)

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Active sclerosis

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds. Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. F. F. Smith, M. D.

(Address) Bay View Hospital

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63245

D 63245

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S.V.HOSP.#56

CITY OF BALTIMORE: (No. Ft. McHenry, Md. ST. 24 WARD)

2-FULL NAME VITO NARDONE

REGISTERED NO.  
(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)(a) RESIDENCE No. U.S.V.HOSP.#56, Ft. McHenry, Md ST., 40 WARD  
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed,  
or Divorced, (write the word)

M W Single

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years Months Days If LESS than  
1 day, hrs.  
or min.  
30 - - -

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work Coal Miner 886(b) General nature of industry,  
business, or establishment in  
which employed (or employer) ---

(c) Name of employer ---

9 BIRTHPLACE (city or town) Italy  
(State or country)

10 NAME OF FATHER ---

11 BIRTHPLACE OF FATHER (city or town) --  
(State or country)

12 MAIDEN NAME OF MOTHER --

13 BIRTHPLACE OF MOTHER (city or town) --  
(State or country)

14 Informant Edgar T. Rosenbrock, Registrar

(Address) U.S.V.HOSP.#56, Ft. McHenry, Md.

15 Filed Robert P. Harrison,

Registrar

Burial Permit Clerk.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1922

17 I HEREBY CERTIFY, That I attended deceased from  
Feb. 4, 1922, to April 6, 1922,  
that I last saw him alive on April 6, 1922,

and that death occurred, on the date stated above, at 2:25 pm.

The CAUSE OF DEATH\* was as follows:

Chr. Pulmonary Tuberculosis, far  
advanced and active

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? no

What test confirmed diagnosis? Clinical Record report

(Signed) M. H. Foster, M. D.

4/6/22 (Address) M. H. FOSTER,  
SURGEON, U.S.P.H.S.  
Ft. McHenry, Md.\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Clarksburg, W. Va. 4/7, 1922

20 UNDERTAKER

J. Linnson + Bros. E. Balt.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 63246

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63246

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Marlborough St.* St. *14* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....

(Residence in Baltimore: No. *Eutan Place & Wilson* St.; yrs. *60* mos. *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE

*White*

5-Single, Married, Widowed, or Divorced, (Write the word.) *Single*

6-DATE OF BIRTH

*July* *25* *1848*  
(Month) (Day) (Year)

7-AGE

*73* yrs. *9* mos. *2* ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER, (State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER, (State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

*1922*

*Robert S. Harrison,*

*Burial Permit Clerk.*

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

*April* *6* *1922*  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquiry* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

*opsy* find that said deceased came to *his* death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Suicide by gun shot*  
*wound in head.*

*Instant death.* (Duration)..... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. .... mos. .... ds.

(Signed) *J. T. Harrison* M. D.

(Coroner.) *April 6, 1922* (Address) *2802 Edmondson*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Balti Haven*

*April 9* *1922*

20-UNDERTAKER

ADDRESS

*Wanda Soudheim*

*148 W. Mt Royal Ave*

D 63247 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63247

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 17 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Coward(a) RESIDENCE. No. 937 Sheilds Alley ST.  WARD. 

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs.  mos.  ds. How long in U. S., if of foreign birth?  yrs.  mos.  ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown6 DATE OF BIRTH (month, day, and year) 1851 ?7 AGE Years 70 ? Months -- Days -- If LESS than 1 day,  hrs.  min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown (State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)14 Informant Hospital Records, (Address) Municipal Hospital15 Robert P. Harrison, 19 1922

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 19 2217 I HEREBY CERTIFY, That I attended deceased from April 1, 19 22, to April 2, 19 22, that I last saw her alive on April 2, 19 22, and that death occurred, on the date stated above, at 2:15 P.M.

The CAUSE OF DEATH\* was as follows:

Chronic nephritis(duration) 5 yrs.  mos.  ds.

CONTRIBUTORY (Secondary)

(duration)  yrs.  mos.  ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.4/3/22 (Address) Municipal Hospital.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

McKiburn Cemetery 4-8-22 19

20 UNDERTAKER

ADDRESS

John B. Pryor & Mulhony St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63248

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 320 Camel ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 320 Camel St.; 20 yrs.,    mos.,    ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, col 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, married  
(Write the word.)6-DATE OF BIRTH, 18 8 2, 1  
(Month) (Day) (Year)7-AGE, 40 years If LESS than 1 day,    hrs. or    min.  
yrs. mos. ds.8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, house wife  
(b) General nature of industry, business, or establishment in which employed (or employer)   9-BIRTHPLACE, (State or Country), Fredrick co, Md10-NAME OF FATHER, Samuel Warman11-BIRTHPLACE OF FATHER (State or Country), Fredrick co Md12-MAIDEN NAME OF MOTHER unknown13-BIRTHPLACE OF MOTHER (State or Country), unknown

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), George W. Watt(Address), 320 Camel St

## 15-

Filed,   , 1912,    Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 6, 1922  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from March 6 1922, to Apr 6 1922,  
that I saw him alive on Apr 5 1922,  
and that death occurred, on the date stated above, at 7:15 A m.  
The CAUSE OF DEATH\* was as follows:  
Cerebral hemorrhage(Duration)    yrs.    mos.    ds.CONTRIBUTORY (Secondary) Acute bronchitis(Duration)    yrs.    mos. 30 ds.(Signed) Chas. J. Keller M. D.Apr 7, 1922 (Address) 2280 Monument

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death    yrs.    mos.    ds. In the State    yrs.    mos.    ds.Where was disease contracted, if not at place of death?   Former or usual residence   

## 19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Samuel Cemetery 4-10-22, 1912

## 20-UNDERTAKER ADDRESS

Felix B. Pye 102 E. Mulberry St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

D 7-1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63249

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *700 N. Wolfe*ST. *7*

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Marion Louisa Fisher*(Residence in Baltimore: No. *720 N. Wolfe*St. *Lt.* yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Female*

## 4-COLOR OR RACE,

*white*5-SINGLE, *Single*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

*Feb**22**1922*

(Month)

(Day)

(Year)

## 7-AGE,

*1**mos.**15**ds.*

If LESS than 1 day,

...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *000*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country),*Baltimore Md.*

## 10-NAME OF FATHER,

*Harry Fisher*11-BIRTHPLACE OF FATHER  
(State or Country),*Baltimore Md.*

## 12-MAIDEN NAME OF MOTHER

*Naomi Fisher*13-BIRTHPLACE OF MOTHER  
(State or Country),*Baltimore Md.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Naomi Fisher*(Address) *720 N. Wolfe St.*

## 15-

Filed

*ROBERT F. HARRISON,*

191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*April**6**1922*

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Feb 22 1922**to April 6 1922*that I saw her alive on *April 1 1922*and that death occurred, on the date stated above, at *P* m.

The CAUSE OF DEATH\* was as follows:

*Spina Bifida*(Duration) *1* yrs. *1* mos. *15* ds.CONTRIBUTORY  
(Secondary)(Duration) *1* yrs. *1* mos. *15* ds.(Signed) *John S. Lundy* M. D.*4/6 1922* (Address) *3522 Greenmount*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *1* mos. *15* ds. In the State *1* yrs. *1* mos. *15* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Baltimore Cemetery*

## DATE OF BURIAL,

*April 8, 1922*

## 20-UNDERTAKER

*Wm. H. Hartley*

## ADDRESS

*815 N. Washington*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1922

D 63250

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63250

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1334 N Caroline ST. 9 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Henry Miller

## (a) RESIDENCE NO.

1334 N Caroline ST.

## WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Wilhelmina Miller

6 DATE OF BIRTH (month, day, and year)

July 19-1943

7 AGE

78 Years

Months

9

Days

14

If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Harmonist

(b) General nature of industry, business, or establishment in which employed (or employer)

himself

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

John Miller

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

## PARENTS

14

Informant (Address)

William Miller  
1334 N Caroline ST.

15

Filed

Robert F. Miller

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1922

17

I HEREBY CERTIFY, That I attended deceased from

4/4, 1922, to 4/5, 1922.that I last saw him alive on 4/5, 1922.and that death occurred, on the date stated above, at Even m.

The CAUSE OF DEATH\* was as follows:

Myocardial insufficiency(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Pulmonary edema  
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed)

1008 Cathedral

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

NOVA

20 UNDERTAKER

Not Carmel Cemetery  
Mrs. C. Miller

ADDRESS

2334 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

D 63251

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63251

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE (No. 1921 E 30<sup>th</sup> ST., 9 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2. FULL NAME

Elsa Henrietta Sonnenborn

## (a) RESIDENCE NO.

1921 E 30<sup>th</sup> St

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 2 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 9, 1905

7 AGE Years Months Days If LESS than 1 day, hrs. or min.  
17 2 28

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.  
(State or country)

10 NAME OF FATHER Louis Sonnenborn

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER Emma Peterson

13 BIRTHPLACE OF MOTHER (city or town) Balt. Md.  
(State or country)14 Informant Louis Sonnenborn  
(Address) 1921 E 30 St

15 1922 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1922

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1922, to Apr 7, 1922.

that I last saw her alive on April 6, 1922.

and that death occurred, on the date stated above, at 2:15 a.m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY acute Oedema  
(Secondary)

(duration) yrs. mos. 2 hrs.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none  
(Signed) Thos H. Stevens, M. D.

4/7, 1922 (Address) 2878 Stanford Rd

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL  
London Park Cem Apr 10 192220 UNDERTAKER  
Wm J. Tucker & Sons North St



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should

D 63252

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. *432 N. Fulton Ave* ST. *16* WARD)

FULL NAME

*Geo. W. Hayswood*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *432 N. Fulton Ave*

St.: yrs. *50* mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*male*

4-COLOR OR RACE,

*white*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *widow*

6-DATE OF BIRTH,

*April 9, 1851*  
(Month) (Day) (Year)

7-AGE,

*71* yrs. *11* mos. *27* ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

*sail maker*  
*OSla*

9-BIRTHPLACE, (State or Country),

*Va*

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Mr. W. P. Hayswood*

(Address)

*432 N. Fulton Ave*

15-

Filed

191

Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*April 6, 1922*  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

*opsy* and that said deceased came to *his* death (Inquest, au-  
opsy or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Cerebral hemorrhage*

(Duration) yrs. mon. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mon. ds.

(Signed) *J. T. Hayswood* M. D.

(Coroner.)

*April 6, 1922* (Address) *280 E. Baltimore St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mon. ds. State... yrs. mon. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Dorsey Md April 8, 1922*

20-UNDERTAKER

ADDRESS

*Wm. J. Hickman 280 E. Baltimore St.*

8-1922

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63253

D 63253

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 N. Stricker ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Felix Casey

## (a) RESIDENCE. NO.

1108 N. Stricker ST.,

WARD

Natchez Miss.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

col.

5 Single, Married, Widowed, or Divorced (write the word)

widower

5a If married, widowed, or divorced

HUSBAND of

(or WIFE of)

Emma Casey

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

71 yrs

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Minister 018

(b) General nature of industry, business, or establishment in which employed (or employer)

Pastoral

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Natchez, Miss

10 NAME OF FATHER

Felix Casey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Natchez, Miss

12 MAIDEN NAME OF MOTHER

Emma Blanton

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Natchez, Miss

14

Informant (Address)

Robt Jefferys 1108 N. Stricker ST.

15

Filed

19

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

6 Apr. 1922

17

I HEREBY CERTIFY, That I attended deceased from

25 Mar. 1922, to 6 Apr. 1922.

that I last saw him alive on

5 Apr. 1922

and that death occurred, on the date stated above, at

2:30 p.m.

The CAUSE OF DEATH\* was as follows:

Acute  
Nephritis

(duration)

about 21

mos. ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Home.

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Chemical

(Signed)

Mayfield Boyd M. D.

(Address)

421 N. Caroline ST.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn Ct

April 9 1922

20 UNDERTAKER

L. B. Brown &amp; Son 108 N. Mont

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

PR-1922

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

No other abnormal  
condition as far  
as phy. could  
determine.

155020.  
D 63254

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63254

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 22 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Laura Johnson(a) RESIDENCE NO. 652 Keweenaw St. City WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced

~~Married~~ of Marie Payne (niece)Same address6 DATE OF BIRTH (month, day, and year) Feb. 17, 18767 AGE Years 52 Months 1 Days 19 If LESS than 1 day, hrs or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER Benjamin Gross11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Lydell Kline13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant JOHNS HOPKINS HOSPITAL (Address) Robert P. Harrison15 8-10-22 Burial Permit Clerk Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5, 192217 I HEREBY CERTIFY, That I attended deceased from April 5, 1922 to April 5, 1922, that I last saw her alive on April 5, 1922, and that death occurred, on the date stated above, at 8:20 P. m.

The CAUSE OF DEATH\* was as follows:

Myocardial Insufficiency(duration) yrs. 8 mos. — ds.CONTRIBUTORY Arteriosclerosis, Aortic (Secondary) Insuff., Chr. Nephritis (duration) yrs. 4 mos. — ds.18 Where was disease contracted if not at place of death? at homeDid an operation precede death? No. Date ofWas there an autopsy? YesWhat test confirmed diagnosis? None (Autopsy)(Signed) Francis R. Dienaide M. D.Date Apr. 6, 1922 (Address) Johns Hopkins Hospital

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL at Auburn Cemetery DATE OF BURIAL 4/9, 192220 UNDERTAKER Mrs. Gertrude Hooper ADDRESS 406 W. Conway



D 63255

HEALTH DEPARTMENT—CITY OF BALTIMORE

63255

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Woman's Hospital* ST. *14* WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Selma Olivia Matilda Johnson*(a) RESIDENCE NO. *1404 Madison Ave* ST. *City*

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *34* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *female* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 30, 1884*7 AGE Years *38* Months Days If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *School Teacher*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Christiania* (State or country) *Norway*10 NAME OF FATHER *Mathias Johnson*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Sweden*12 MAIDEN NAME OF MOTHER *Lena Andersen*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Sweden*14 Informant *Miss Gertrude Le Boone* (Address) *4009 Belle Ave*15 *8-10-22* *Robert J. Clark* Registrar

## MEDICAL CERTIFICATE OF DEATH

15 DATE OF DEATH (month, day, and year) *Apr. 6, 1922*17 I HEREBY CERTIFY, That I attended deceased from *Mar. 29*, 1922, to *Apr. 6*, 1922,that I last saw her alive on *Apr. 6*, 1922, and that death occurred, on the date stated above, at *10:20 A.M.*

The CAUSE OF DEATH\* was as follows:

*Asphyxia (operative) (Removal of mediastinal thyroid) surrounding trachea*CONTRIBUTORY *Pulmonary atelectatic cavity.* (Secondary) (duration) *7* yrs. *7* mos. *7* ds.18 Where was disease contracted *?* if not at place of death?Did an operation precede death? *Yes* Date of *Apr. 6, 1922*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *G. F. Hoff* M. D., 19 (Address) *Woman's Hospital*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Green Mount* *4/8* 1922

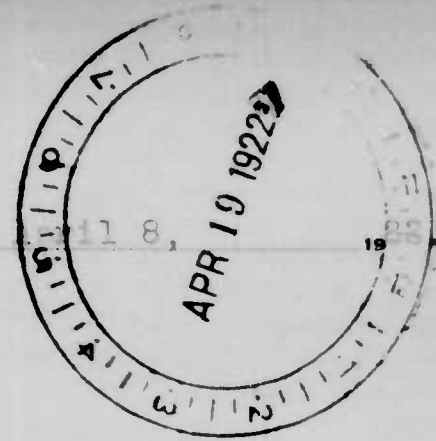
20 UNDERTAKER ADDRESS

*Martin Baker & Son* *1827 76 North*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

Hospital for the Women of Maryland

BALTIMORE, MD.



Dr. C. Hampton Jones,  
Commissioner of Health Department,  
Health Department,  
Baltimore, Maryland.

My dear Dr. Jones:

In compliance with your telephone call of April 8th, I am sending the following information concerning the death of Miss Selma O. M. Johnson.

The patient was operated by Dr. Follis for colloid hypertrophy of the thyroid extending into the mediastinum, forming a mass about the size of an orange, part of which extended around behind the trachea, causing pressure and flattening of the trachea. This condition had been present for some months and the patient had developed an extensive bronchitis and evidently partial bronchiectasis or a pulmonary abscess which had not been recognized before operation. At operation the mass was easily and successfully removed. Intratracheal anesthesia of ether mixed with oxygen was given by means of a tracheal tube extending down to the bifurcation. The patient was in perfect condition until the head and shoulders were lowered in order that the wound might be closed. Suddenly her respirations became very labored and ceased. It was noted that oxygen, which had been given alone for the previous five or ten minutes was bubbling through a fluid in the trachea. A tracheotomy was immediately done by Dr. Follis, and it was discovered that the trachea was completely filled

Hospital for the Women of Maryland

BALTIMORE, MD.,

19

#2

with a thick purulent material. From this it was concluded that during the course of the operation, a large bronchiectatic or abscess cavity had ruptured, discharging its contents into the bronchi and with the lowering of the head and shoulders this material welled up into the trachea, making it impossible to force oxygen into the lung proper. Evidently the patient had died from a mechanical obstruction to the air passage.

Very truly yours,

*A. F. Goff M.D.*  
*Woman's Hospital*

GFG:MG

D 63256

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63256

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2002 Penrose Ave ST., 30 WARD)

## REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. 2002 Penrose Ave ST., 20 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 67 1 13

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa10 NAME OF FATHER Mr Callis11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa12 MAIDEN NAME OF MOTHER Williams13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

## 14

Informant (Address) Mrs Mable Gursk  
2002 Penrose Ave

## 15

81022

ROBERT E. HARRISON,

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8<sup>th</sup> 192217 I HEREBY CERTIFY, that I attended deceased from April 7<sup>th</sup> 1922 to April 8<sup>th</sup> 1922 that I last saw him alive on April 7<sup>th</sup> 1922and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral HemorrhageCONTRIBUTORY (Secondary) Paralytic (duration) yrs. mos. 4 ds.18 Where was disease contracted if not at place of death? PaDid an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? None(Signed) Robert E. Harrison, M. D.(Address) 530 N Fullerton

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Burial Island via Callis RdApril 9, 1922

20 UNDERTAKER

ADDRESS

John F. Denny754 Light

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PR-



D 63257

## HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63257

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Joe St.* ST. WARD)

2-FULL NAME

*Carol Vinton*(Residence in Baltimore: No. *1408 n Bond*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*Male*

4-COLOR OR RACE,

*W*5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)*Single*

6-DATE OF BIRTH

*Jan 16, 1911*

(Month) (Day) (Year)

7-AGE,

*11 yrs. 2 mos. 20 ds.*

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*Seamstress**ooo*

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

*Robert S. Vinton*

11-BIRTHPLACE OF FATHER

(State or Country),

*Balto*

12-MAIDEN NAME OF MOTHER

*Isabel Stevens*

13-BIRTHPLACE OF MOTHER

(State or Country),

*Balto*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Robert S. Vinton*

(Address)

*1408 n Bond*

15-

Filed

*Robert S. Vinton*

191

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*April 6, 1922*  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

*Inquest, autopsy or inquiry.*

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry) find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Pharmaceutical**by auto* (Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Wm. S. Vinton* D.(Address) *47 n Bond*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

*Balto. Cem.*

DATE OF BURIAL,

*Apr. 8, 1922*

20-UNDERTAKER

*Wm. C. Black 927 N. Broadway*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

A-8 022



CITY HALL  
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

## CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 17 DAY December  
OF 1964 THE MICROPHOTOGRAPHS APPEARING  
#D 60446-  
HEREIN STARTING WITH Jan. 19, 1922 AND  
#D-63257-  
ENDING WITH April 8, 1922 ARE AC-  
CURATE AND COMPLETE REPRODUCTIONS OF THE  
RECORDS OF THE DEPARTMENT OF Health  
BUREAU OF: Vital Statistics AS DELIVERED  
IN THE REGULAR COURSE OF BUSINESS FOR  
PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM  
MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU  
OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC  
COPY.

CAMERA OPERATOR: D. McPaul



**END OF REEL**